MHN

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JULIE GOPON,

Plaintiff,

v.

CITIGROUP HEALTH BENEFIT PLAN,

Defendant.

07CV6768
JUDGE HOLDERMAN
MAGISTRATE JUDGE SCHENKIER

COMPLAINT

Now comes the Plaintiff, JULIE GOPON, by her attorneys, MARK D. DE BOFSKY, and DALEY, DE BOFSKY & BRYANT, and complaining against the Defendant, CITIGROUP HEALTH BENEFIT PLAN, she states:

Jurisdiction and Venue

1. Jurisdiction of this Court is based upon the Employee Retirement Income Security Act of 1974 (ERISA); and, in particular, 29 U.S.C. §§1132(e)(1) and 1132(f). Those provisions give the district court jurisdiction to hear civil actions brought to recover benefits due under the terms of an employee welfare benefit plan which, in this case, consists of a group health benefit plan administered for the benefit of employees of Citigroup, Inc. ("Citigroup"), including retirees.

2. The ERISA statute provides, at 29 U.S.C. §1133, a mechanism for administrative or internal appeal of benefit denials. Those avenues of appeal have been exhausted.

3. Venue is proper in the Northern District of Illinois. 29 U.S.C. §1132(e)(2), 28 U.S.C. §1391.

Nature of Action

4. This is a claim seeking an award to Plaintiff of health benefits pursuant to a group health care plan for employees of Citigroup, including retirees (a true and correct copy of the most recent summary plan description available to plaintiff (Dated January 1, 2006) is attached hereto and by that reference incorporated herein as Exhibit "A"). This action, seeking recovery of benefits, is brought pursuant to §502(a)(1)(B) of ERISA (29 U.S.C. §1132(a)(1)(B)).

The Parties

5. The Plaintiff, Julie Gopon ("Gopon") (DOB 8/xx/43), is and was a resident of Highland Park, Illinois at all times relevant hereto. At all times relevant hereto, Plaintiff has been an insured beneficiary of an employee welfare benefit plan maintained by Citigroup.

6. The Defendant, Citigroup Health Benefit Plan ("Plan"), is a comprehensive medical benefit plan provided by Citigroup to its employees, including retirees such as Gene Gopon, the plaintiff's spouse who became a Citigroup retiree when his prior employer, Associates First Capital, was acquired by Citigroup. The plan administrator is identified in the summary plan description as the Plans Administration Committee. At all times relevant hereto, the Plan was engaged in the business of administering health and welfare benefits within the Northern District of Illinois.

7. At all times relevant hereto, the Plan constituted an "employee welfare benefit plan" as defined by 29 U.S.C. §1002(1); and incident to her husband's prior employment with Citigroup, Gopon received coverage under the Plan as a "beneficiary" as defined by 29 U.S.C. §1002(8). This claim relates to benefits under the foregoing Plan.

Statement of Facts

8. Gopon has been diagnosed with Hepatitis C (HCV), a virus which affects the functioning of the liver. Gopon's treating physician, Dr. Jeffrey Glass, a specialist in diseases of the liver, prescribed the medications Pegasys and Copegus to treat her condition. Those medications have significantly lowered the HCV viral load in Gopon's liver, and Dr. Glass has continued to prescribe that treatment to suppress the virus and prevent the progression of liver damage.

9. The Plan's Prescription Drug Program is managed by Express Scripts, Inc. ("Express Scripts").

10. Express Scripts initially approved coverage for Pegasys and Copegus, but in September 2007 denied coverage for a refill of the medications despite their efficacy. Express Scripts' stated reason for the denial was that the medications were "not covered for maintenance therapy" pursuant to the Plan's summary plan description (SPD). Express Scripts failed to identify what specific provisions of the SPD supported its determination.

11. Gopon appealed the denial, and supported her appeal with a report from Dr. Glass stating Gopon continues to require the medication to treat her condition and is in danger of an exacerbation of her symptoms due to HCV if the medication is not provided.

12. Express Scripts referred Gopon's appeal to MCMC LLC ("MCMC") for review. On September 29, 2007, MCMC notified Gopon of its decision to uphold the denial of coverage. MCMC stated an entirely different reason for the denial than the one previously stated. MCMC stated the medications were "not medically necessary." MCMC did not identify what provisions of the Plan supported its denial or whether it even had the correct Plan document.

13. MCMC further advised Gopon that it had consulted with and received a report from Dr. Dunzendorfer, dated September 29, 2007. Dr. Dunzendorfer did not examine Gopon, did not have access to or request Gopon's complete medical records, and did not consult with her treating physician in preparing his report. Contrary to the opinion of Gopon's treating physician, Dr. Dunzendorfer opined that Gopon should no longer receive the medications because they did not reduce the viral road to zero, notwithstanding that the medications had proven results in significantly reducing the viral load in her liver. MCMC's consultant also opined that the medications should be withheld until additional liver damage had occurred which could lead to the necessity of a liver transplant.

14. Despite repeated requests, MCMC has failed to provide Gopon with information about Dr. Dunzendorfer's medical qualifications.

15. In response to requests by Gopon as to what provisions of the Plan it based its decision on, MCMC issued an addendum to its decision dated October 23, 2007. In its addendum, MCMC referred to page 20 of the Citigroup Summary Plan Description (SPD). MCMC also sent Gopon a copy of an SPD dated January 1, 2006. However, page 20 of the SPD provided to Gopon (a true and correct copy of which is attached hereto and by that reference incorporated herein as Exhibit "B") contains no language relevant to prescription drug coverage under the Plan. Despite repeated requests, MCMC has continually failed to provide what specific provisions it relied upon to make its decision. Moreover, MCMC has failed to provide Gopon with a current SPD or assure Gopon that it based its decision on the current SPD.

16. On October 23, Gopon appealed the denial a second time, and submitted additional medical records supporting her ongoing need for Pegasys and Copegus.

17. Despite this additional information, MCMC again upheld its decision to deny coverage on October 31, 2007, stating that the medications constituted maintenance therapy and were "not medically necessary." MCMC again failed to identify what specific provisions of the plan supported its decision, nor does the plan exclude maintenance therapy.

18. MCMC based its decision on the October 31, 2007 report of Dr. Vinayek, another doctor who did not examine Gopon or have access to her complete medical files. MCMC stated in its decision that Dr. Vinayek spoke to Gopon's treating physician, Dr. Glass; however, Dr. Glass has denied speaking about Gopon's case with anyone from MCMC.

19. Gopon has repeatedly requested information about the names and medical qualifications of all individuals involved in the denial of her prescription drug benefits. Despite these repeated requests, MCMC has failed to provide this information.

20. Gopon has repeatedly requested information about the specific policy provisions upon which her claim was denied. Despite these repeated requests, MCMC has failed to provide accurate information about what SPD it used and what specific provision supports its denial.

21. MCMC's internal documents relating to Gopon's claim also indicate the incorrect Social Security number for the claimant and also reference a different tissue type than that of the claimant, casting further doubt on the reliability of its review of her claim.

22. The Code of Federal Regulations, 29 C.F.R. §2560.503-1(g), requires that claim denials contain the specific reasons for the denial, specific reference to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary. Despite such requirements, Express Scripts and MCMC have failed to provide this required information.

23. The ERISA statute, at 29 U.S.C. §1133, requires adequate notice of denial of benefits as well as an opportunity for a full and fair review of the denial. Based on MCMC's actions, Gopon has been denied a full and fair review of her claim.

24. As a direct and proximate result of the foregoing, based on the evidence submitted to Express Scripts and MCMC establishing that Gopon does require prescription drugs, she is entitled to benefits under the Plan that would cover the cost of these medications.

WHEREFORE, Plaintiff prays for the following relief:

A. That the court enter judgment in Plaintiff's favor and against Defendant and that the court order Defendant to pay health benefits to Plaintiff in an amount equal to the contractual amount of benefits to which she is entitled;

B. That the court determine and then declare that Defendant is required to continue paying Plaintiff benefits so long as she meets the policy terms and conditions for receipt of benefits;

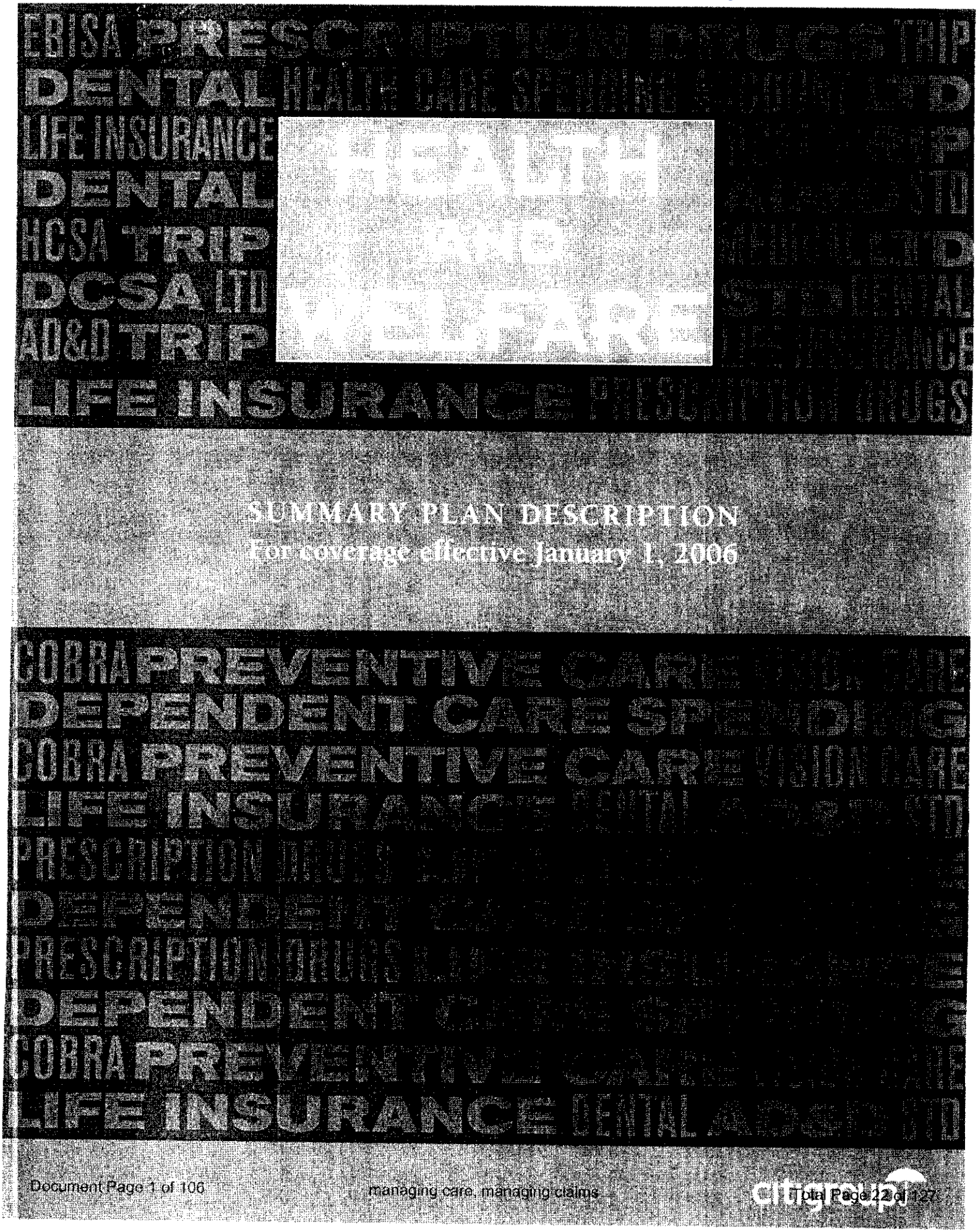
C. That the court award Plaintiff attorney's fees pursuant to 29 U.S.C. §1132(g); and

D. That Plaintiff recover any and all other relief which she may be entitled, as well as the costs of suit.

Dated: November 28, 2007

One of the attorneys for Plaintiff

Mark D. DeBofsky
Daley, DeBofsky & Bryant
55 W. Monroe St., Suite 2440
Chicago, Illinois 60602
(312) 372-5200
FAX (312) 372-2778



managing care, managing claims

IMPORTANT INFORMATION ABOUT THE CONTENTS OF THIS DOCUMENT

This document describes health and welfare benefits for certain U.S. employees of Citigroup Inc. ("Citigroup") and its participating companies (collectively the "Company") as in effect January 1, 2006. The benefits described in this document are:

- **CITIGROUP MEDICAL PLAN**
  - Aetna ChoicePlan 100, 250, and 500;
  - CIGNA ChoicePlan 100, 250, and 500;
  - Empire BlueCross BlueShield ChoicePlan 100, 250, and 500;
  - UnitedHealthcare ChoicePlan 100, 250, and 500;
  - Health Plan 2000;
  - Hawaii Health Plan;
  - Out-of-Area Health Plan;
  - Health maintenance organizations; and
  - Citigroup Prescription Drug Program.
- **CITIGROUP DENTAL PLAN**
  - CIGNA Dental Care DHMO (dental health maintenance organization);
  - Delta Dental; and
  - MetLife Preferred Dentist Program (PDP).
- **CITIGROUP VISION CARE PLAN;**
- **CITIGROUP SHORT-TERM DISABILITY PLAN;**
- **CITIGROUP LONG-TERM DISABILITY PLAN;**
- **SPENDING ACCOUNTS**
  - Health Care Spending Account (HCSA);
  - Dependent Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP).
- **LIFE INSURANCE**
  - Citigroup Basic Life and Accidental Death and Dismemberment (AD&D) Insurance;
  - Optional Group Universal Life (GUL) and Supplemental AD&D Insurance*; and
  - Citigroup Business Travel Accident Insurance.
- **CITIGROUP LONG-TERM CARE INSURANCE PLAN.**

* While many of these benefits are provided under employee benefit arrangements sponsored by Citigroup, the Optional GUL insurance coverage above is offered solely as a convenience to Citigroup employees and isn't endorsed by the Company.

This summary has been written, to the extent possible, in non-technical language to help you understand the basic terms and conditions of the health and welfare benefit plans described above (the "Citigroup Health and Welfare Plans or collectively the "Plans" and individually a "Plan") as they're in effect. This description is intended to be only a summary of the major highlights of the Plans. Details can be found in the Plan documents.

The Plans are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), with the exception of DCSA, TRIP, and Optional GUL and Supplemental AD&D insurance. This document serves as a summary plan description (SPD) for the Plans subject to ERISA. To the extent applicable, the Plans will be interpreted and administered in accordance with ERISA, the Internal Revenue Code of 1986, as amended (the "IRC"), and applicable law.

No general explanation can adequately give you all the details of the Plans. This general explanation doesn't change, expand, or otherwise interpret the terms of the Plans. If there's any conflict between this SPD and the Plan documents (including any related insurance contracts), the terms of the Plan documents — including any related insurance contracts — will be followed in determining your rights and benefits under the Plans.

Citigroup may change or discontinue the Plans or any part thereof at any time without notice.

This document is neither a contract nor a guarantee of continued employment for any definite period of time. Your employment is always on an at-will basis.

This document includes summary information about the federal tax treatment of employee benefits. It doesn't address state or local tax consequences. The information provided here is general guidance only and may not be relied on as tax advice for any purpose. Citigroup Inc. and its affiliates aren't in the business of providing personal tax or legal advice to its employees. The information in this document isn't intended or written to be used — and can't be used or relied on — by any taxpayer to avoid tax penalties. For information on how applicable tax law may apply to your personal situation, consult your tax adviser.

AN INTRODUCTION TO YOUR SUMMARY PLAN DESCRIPTION

Citigroup offers a variety of health and welfare benefits to meet your needs. The following information describes the health and welfare benefits available effective January 1, 2006. For a copy of the Plan documents, visit http://benefitsbookonline.com. The 2006 provisions, described here, should be available in the Plan documents in early 2006.

Save this book as it'll be used for more than one year.

THIS BOOK IS DIVIDED INTO THREE SECTIONS:

SECTION 1

General information includes:

- Benefits overview;
- When you must enroll;
- Eligibility and definition of eligible dependents;
- Domestic partner benefits;
- Coordination of benefits;
- Coverage categories;
- Qualified changes in status;
- How to file a claim; and
- Glossary.

SECTION 2

Plan provisions include details of the following Plans:

- Medical Plan: ChoicePlan 100, 250, and 500; Health Plan 2000; Hawaii Health Plan; and the Out-of-Area Health Plan;
- Citigroup Prescription Drug Program;
- Dental;
- Vision Care Plan;
- Disability;
- Life/AD&D insurance;
- Long-Term Care insurance; and
- Spending accounts.

SECTION 3

Legal and administrative information includes:

- When coverage ends;
- Notice of HIPAA Privacy Practices;
- COBRA;
- Recovery provisions;
- Claims and appeals; and
- ERISA information.

CONTENTS

SECTION 3-LEGAL AND ADMINISTRATIVE INFORMATION

TELEPHONE AND WEB SITE DIRECTORY

If you have intranet or Internet access, you also can review many of your benefits and obtain benefit information through Total Comp at Citigroup at https://www.totalcomponline.com.

BENEFITS SERVICE CENTER	
Available by choosing the "health and welfare benefits" option of ConnectOne	
For eligibility and general information about the health and welfare Plans	1-800-881-3938 1-972-652-4582 (from outside the United States)
For Plan information and to enroll, visit the Internet.	**https://mybenefits.csplans.com**
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)	
ADP	1-800-422-7608
DENTAL	
CIGNA Dental Care DHMO	1-800-367-1037 **http://www.cigna.com** **http://www.mycigna.com (participants only)**
Delta Dental	1-877-248-4764 **http://www.deltadentalpa.org/citigroup**
MetLife Preferred Dentist Program (PDP)	1-888-832-2576 **http://www.metlife.com/dental**
DEPENDENT CARE SPENDING ACCOUNT	
ADP	1-800-378-1823 **http://www.flexdirect.adp.com/citigroup**
DISABILITY	
MetLife	
For Short-Term Disability (STD), Long-Term Disability (LTD), and Family and Medical Leave Act (FMLA) information	
To report a disability, choose the "managed disability" option of ConnectOne.	1-800-881-3938
You also can report a disability by calling MetLife directly.	1-888-830-7380
HEALTH CARE SPENDING ACCOUNT	
ADP	1-800-378-1823 **http://www.flexdirect.adp.com/citigroup**

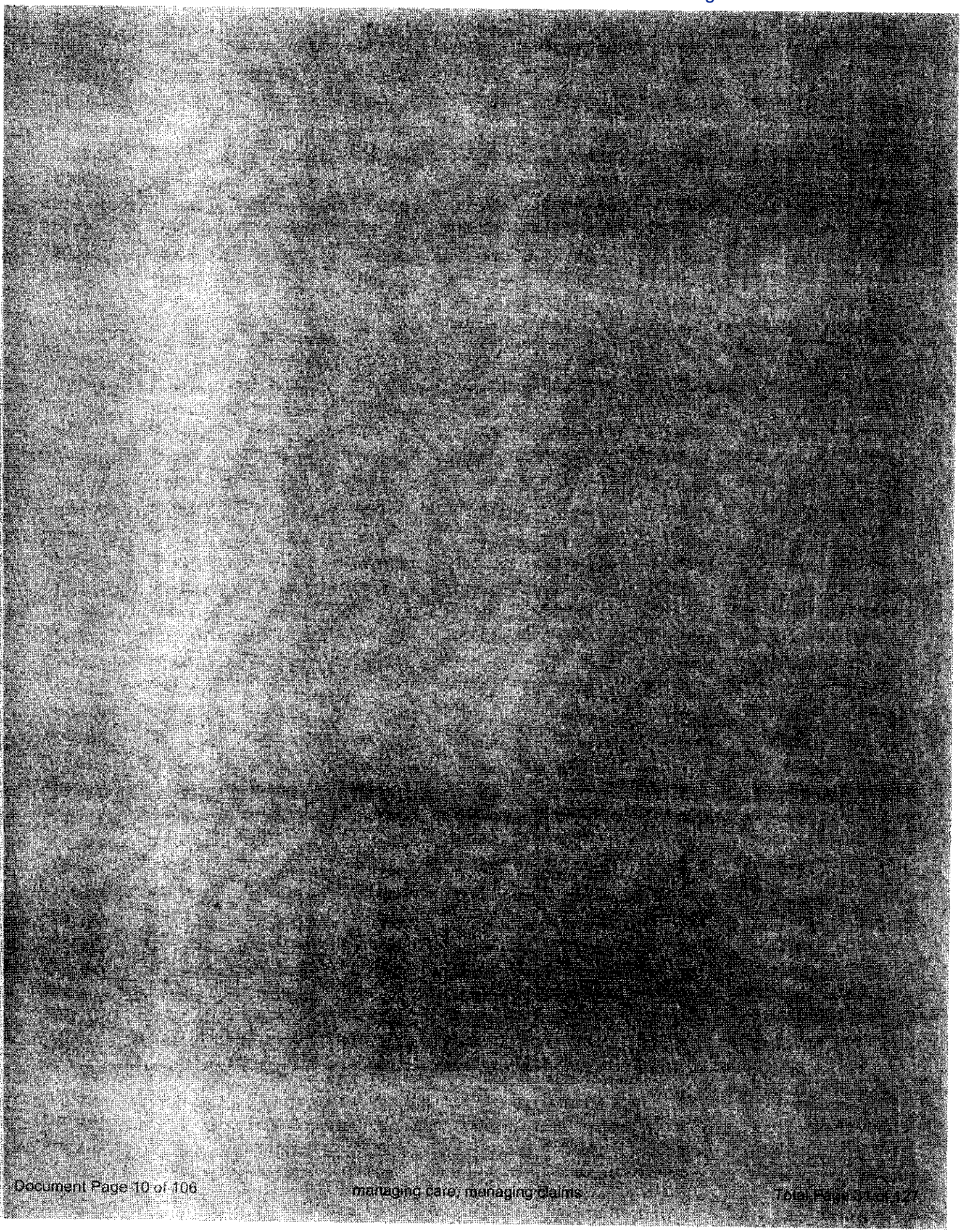
TELEPHONE AND WEB SITE DIRECTORY

HMOS (HEALTH MAINTENANCE ORGANIZATIONS)	
Citigroup HMO Information Line For general information about HMOs For specific information about an HMO, call the telephone number on your HMO information sheet. Once enrolled in an HMO, call the telephone number on your HMO ID card.	1-800-422-6106
LIFE/ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE	
Benefits Service Center; available by choosing the "health and welfare benefits" option of ConnectOne For general information and to enroll	1-800-881-3938 1-972-652-4582 (from outside the United States)
LONG-TERM CARE INSURANCE	
John Hancock Life Insurance Co.	1-800-222-6814 **http://groupltc.jhancock.com** User name: groupltc, password: mybenefit
MEDICAL (NON-HMO PLANS)	
Aetna	1-800-545-5862 1-800-325-2298 (TDD) **http://www.aetna.com**
CIGNA	1-800-794-4953 **http://www.cigna.com** **http://www.mycigna.com (participants only)**
Empire BlueCross BlueShield	1-866-290-9098 **http://www.empireblue.com**
UnitedHealthcare	1-877-311-7845 1-800-842-0090 (TDD) **http://www.provider.uhc.com/citigroup** (public site for Citigroup employees) **https://www.myuhc.com** (participants only)
Out-of-Area Health Plan (Empire BlueCross BlueShield)	1-866-290-9098 **http://www.empireblue.com**
Hawaii Health Plan (UnitedHealthcare) Health Plan 2000	1-877-311-7845 1-800-842-0090 (TDD) **http://www.provider.uhc.com/citigroup** (public site for Citigroup employees) **https://www.myuhc.com** (participants only)

TELEPHONE AND WEB SITE DIRECTORY

PLAN DOCUMENTS	**http://www.benefitsbookonline.com**
PRESCRIPTION DRUG PROGRAM Express Scripts To refill an Express Scripts Home Delivery prescription using the automated system; for instructions on how your doctor can fax your prescription to the Express Scripts Pharmacy; to arrange credit card payment for all your home delivery pharmacy service orders For "prior authorization"	1-800-227-8338 1-800-899-2114 (TTY) **https://member.express-scripts.com/preview/citigroup** (public site for Citigroup employees) **http://www.express-scripts.com** (participants only) 1-800-224-5498
TOTAL COMPENSATION WEB SITE	**https://www.totalcomponline.com**
TRANSPORTATION REIMBURSEMENT INCENTIVE PROGRAM (TRIP) ADP	1-800-378-1823 **http://www.flexdirect.adp.com/citigroup**
VISION CARE PLAN Davis Vision For information and laser vision correction providers/arrangements	1-877-923-2847 Enter code 2227 **http://www.davisvision.com**

SECTION 1
GENERAL INFORMATION



SECTION 1-GENERAL INFORMATION

BENEFITS OVERVIEW

Citigroup provides a basic level of benefits coverage, called core benefits, as well as the opportunity to enroll in additional coverage to protect yourself and your family. Coverage is effective on your date of hire or the date you become eligible for benefits. Other than for the core benefits, described immediately below, you must enroll to have coverage.

Core benefits, provided at no cost to you, are:

- Basic Life and Accidental Death and Dismemberment (AD&D) insurance, each equal to your total compensation, up to $200,000, on your date of eligibility; Basic Life insurance is administered by MetLife, while AD&D is administered by CIGNA;
- Business Travel Accident insurance, administered by CIGNA, of up to five times your total compensation to a maximum benefit of $2 million;
- Short-Term Disability (STD) coverage, administered by MetLife, to replace up to 100% of your annual base salary for an approved disability leave of up to 13 weeks; the number of weeks at 100% pay will depend on your length of service with Citigroup; see page 50 for the STD schedule of benefits that applies to you; and
- If your total compensation is less than or equal to $50,000.99, Long-Term Disability (LTD) coverage, administered by MetLife, equal to 60% of your total compensation.

Additional benefits you'll want to consider, based on your individual circumstances, are:

- Benefits paid with pretax dollars:
  - Medical;
  - Dental;
  - Vision care;
  - Health Care Spending Account;
  - Dependent Care Spending Account; and
  - Transportation Reimbursement Incentive Program (TRIP). See accompanying box for information about TRIP enrollment and effective date of coverage.
- Benefits paid with after-tax dollars:
  - LTD, if your total compensation is $50,001 and above. **Note:** If your total compensation is less than or equal to $50,000.99, LTD is a core benefit provided at no cost to you;
  - Optional Group Universal Life (GUL) and Supplemental AD&D insurance;
  - Long-Term Care insurance; and
  - Additional TRIP contributions.

ENROLLING IN TRIP

The Transportation Reimbursement Incentive Program (TRIP) allows you to set aside both pretax and after-tax dollars from your pay to reimburse yourself for eligible transportation expenses. You can enroll in TRIP at any time, and your TRIP election will be effective the first of the following month. **Note:** If you happen to enroll in TRIP during the annual enrollment period, your elections also are effective the first of the following month.

WHEN YOU MUST ENROLL

Enrolling in Citigroup health and welfare benefits isn't mandatory. If you don't enroll, you'll have the core coverage described in the previous column.

If you want Citigroup medical and/or dental coverage, you ***must*** enroll during your initial enrollment period. Once enrolled in medical and/or dental coverage, if you don't enroll during subsequent annual enrollments you'll be assigned the same coverage, or, if that coverage is no longer available, to other medical/dental coverage.

If you don't enroll for medical/dental coverage during your initial enrollment period and later decide you want coverage, you can enroll in Citigroup coverage for the following calendar year or as the result of a qualified change in status. See page 12 for a list of qualifying status changes.

If you're enrolling in an HMO for the first time: You must select a primary care physician (PCP) for yourself and each family member you enroll.

AFTER YOU ENROLL OR 'DEFAULT'

After you enroll, a confirmation of enrollment will be made available to you. If you don't enroll, a statement listing your default coverage will be mailed to you.

CONFIRMATION OF ENROLLMENT

If you enroll by telephone: A confirmation statement will be mailed to your home between one and three weeks after you enroll. Your confirmation statement will list your benefit elections and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment.

If you enroll online: Print a confirmation statement after you enroll and before you log out. Retain it as proof of your enrollment. You won't receive a confirmation statement in the mail.

CONFIRMATION OF DEFAULT

If you don't enroll, you'll receive a default statement within several weeks after your enrollment deadline. The default statement will list your default coverage.

If you don't enroll, you'll have the "default" coverage shown on the Citigroup Benefits Web Site or on your Personal Enrollment Worksheet.

HEALTH PLAN ID CARDS

If you enroll as a new hire in:	An ID card will be mailed to you within several weeks after you enroll from:
An HMO	The HMO
ChoicePlan 100, 250, or 500, Health Plan 2000, the Hawaii Health Plan, or the Out-of-Area Health Plan	Medical: Your Plan Prescription drug coverage: Express Scripts
CIGNA Dental Care DHMO	CIGNA Dental

If you need to use a medical provider and haven't received your ID card, show your confirmation statement along with the group number of your medical Plan to your provider. For the group number, call the Benefits Service Center as instructed on page 4. You also can print a temporary ID card from your medical Plan's Web site. The Web addresses are shown in the "Telephone and Web site directory" on page 5.

BENEFICIARY FORMS

Your beneficiary information should be on file with Citigroup. If you've never designated a beneficiary you should visit the Your Benefits Resources℠ Web site at **http://resources.hewitt.com/citigroup/**. Most employees also can link to Your Benefits Resources through Total Comp at Citigroup at **https://www.totalcomponline.com**.

You also can call ConnectOne at 1-800-881-3938. From the main menu, choose the "pension" option. From the "pension" option, follow the prompts for "pension beneficiary information" to name a beneficiary for the Basic Life insurance, Citigroup 401(k) Plan, and Citigroup Pension Plan.

If you enroll in Optional GUL insurance for the first time, you must complete a MetLife Beneficiary Designation-Form 201 available on the Citigroup intranet at **http://www.citigroup.net/human_resources/form.htm** and return it to MetLife at the address on the form.

If you change your beneficiary designation for either Basic Life or Optional GUL, it won't automatically apply to the other Plan. You must change the beneficiary for each Plan separately.

If you retire, the beneficiary you designated while an employee will be carried over to any Company-provided retirement policies you may have until you designate other beneficiaries.

ELIGIBILITY FOR CITIGROUP COVERAGE

ELIGIBILITY AT A GLANCE

If you work in the United States for:
American Health and Life Co; Citibank, N.A. and Participating Cos.; CitiFinancial; Citigroup Corporate Center; Citigroup Global Markets Inc. and its subsidiaries; Citigroup Investment Group; CitiStreet Institutional Division; CitiStreet Total Benefits Outsourcing Division; Primerica Financial Services; and National Benefit Life Insurance Co.

And you're an active*:
- Full-time employee (regularly scheduled to work 40 hours or more a week) or
- Part-time employee (regularly scheduled to work at least 20 or more hours a week)

And
You receive a regular semimonthly or monthly paycheck

Then you're considered an eligible U.S. Citigroup employee for health and welfare benefits and you can enroll in:
- Health and welfare benefits for yourself and
- The medical, dental, vision care, and group life insurance Plans for your eligible dependents.

* If you're on an approved leave of absence, you're eligible to enroll in Citigroup benefits (other than the spending accounts and Long-Term Care insurance); other enrollment restrictions may apply.

If both you and your spouse/domestic partner are employed by Citigroup and are benefits-eligible, each of you can enroll individually or one of you can enroll and claim the other as a dependent. You can't enroll as an individual *and* be claimed as your spouse's/domestic partner's dependent.

WHEN YOU AREN'T ELIGIBLE TO ENROLL

You aren't eligible to enroll in the Plans if:
- Your compensation isn't reported on a Form W-2 Wage and Tax Statement issued by a participating company;
- You're employed by a Citigroup subsidiary or affiliate that isn't a participating company;
- You're engaged under an agreement that states you aren't eligible to participate in the applicable Plan or program;
- You're a non-resident alien performing services outside the United States; or
- You're classified by Citigroup as an independent contractor or consultant.

If you're a U.S. citizen or legal resident employed outside the United States or if you're otherwise unsure whether you're eligible to participate in the Plans, call the Benefits Service Center or contact your local Human Resources department for more information.

NO PRE-EXISTING CONDITION LIMITATIONS

None of the Citigroup medical options has a pre-existing condition limitation or exclusion that would prevent you from enrolling in the Plans or receiving benefits for a specific condition or illness.

DEFINITION OF ELIGIBLE DEPENDENTS

Your eligible dependents must be U.S. citizens or legal residents and generally are:

- Your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common-law marriages; if you're legally separated, your spouse isn't an eligible dependent unless mandated by state law;
- Your domestic partner; see "Domestic partner benefits" beginning on page 14 for details;
- Your domestic partner's eligible dependents; see "Domestic partner benefits" beginning on page 14 for details;
- Your unmarried children who rely on you for a majority of their financial support and who you claim as dependents on your federal tax return and are:
  - Your biological children;
  - Your legally adopted children;
  - Your stepchildren who live with you full time in a regular parent-child relationship; or
  - Any other child permanently living with you for whom you're the legal guardian.

You can cover your unmarried children only if they:

- Are under the age of 19[1]; or
- Are under the age of 25[1] and are full-time students at an accredited school or college (during enrollment each year, you'll be prompted to certify that your eligible child is a student even though you may not be changing medical Plans; you also must provide proof of student status in writing upon request); or
- Were covered under the Plans before age 19, or age 25 as full-time students, and they become incapable of self-sustaining employment due to a disability, in which case they may be eligible for coverage beyond such age.

No dependent can be covered under these Plans as both an employee and as an eligible dependent or as an eligible dependent of more than one employee. If your dependent child accepts a job at Citigroup and is benefits eligible, you must drop your child from your coverage and your child must enroll in his or her own employee benefits.

[1]For information on when coverage ends, see "When coverage ends" on page 73.

COORDINATION OF BENEFITS

Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citigroup Plan and one or more other plans, such as a spouse's or other employer's plan.

The Citigroup Medical Plan and the Citigroup Dental Plan contain a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the applicable Plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the Plan documents.

When you're covered by more than one plan, the primary plan will pay benefits first while the secondary plan will pay benefits after the primary plan has paid benefits.

HOW COORDINATION OF BENEFITS WORKS

- **When the Citigroup Plan is primary:** The Citigroup Plan considers benefits as if a secondary plan doesn't exist, and it will pay benefits first.
- **When the Citigroup Plan is secondary:** The Citigroup Plan will pay the difference, if any, between what you'd have received from Citigroup if it were the only coverage and what you're eligible to receive from the other plan. ***Total benefits will never equal more than what the Citigroup Plan would have paid alone.*** When the Citigroup Plan is secondary and the patient is covered under an HMO, benefits under the Citigroup Plan will be limited to the copayment, if any, for which you'd have been responsible under the HMO, whether or not the services provided are rendered by the HMO. If a service isn't covered or coverage is denied, you'll be responsible for payment.

The Citigroup Plan will be the primary plan for claims:

- For you, if you aren't covered as an employee by another plan;
- For your spouse, if your spouse isn't covered as an employee by another plan; and
- For your dependent children.

Parents' birthdays are used to determine whose coverage is primary for the children. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage. For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is considered the primary plan for your children.

If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

In case of divorce or separation

When a child is claimed as a dependent by parents who are separated or divorced, the primary plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. Otherwise, the Citigroup Plan will be secondary. When a child's parents are separated or divorced and there's no court decree, then benefits will be determined in the following order:

1. The plan of the parent with custody of the child;
2. The plan of the spouse of the parent with custody of the child; and
3. The plan of the parent who doesn't have custody of the child.

In the event of a legal conflict between two plans over which is primary and which is secondary, the plan that has covered the individual for the longer time will be considered primary. When a plan doesn't have a coordination-of-benefits provision, the rules in this provision aren't applicable and such plan's coverage is automatically considered primary.

TOTAL COMPENSATION AND YOUR BENEFITS

Total compensation is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life/AD&D insurance benefits;
- Optional GUL/Supplemental AD&D insurance and costs;
- Eligibility for the DCSA subsidy;
- STD for financial consultants, financial consultant associates, and investment associates in Global Wealth Management and account executives in the Corporate and Investment Bank; and
- Business Travel Accident insurance benefits.

DEFINITION OF TOTAL COMPENSATION

If you're enrolling in benefits as a new hire or newly eligible employee: Your total compensation at the time you're hired is equal to your annual salary plus shift differential. If you're paid on commissions only, your total compensation is calculated differently. Consult your HR representative.

For future years, your total compensation will be based on a formula that includes your actual base pay plus shift differential, commissions, performance-based bonuses, and annual incentive bonus.

If you're enrolling during the annual enrollment period for coverage effective January 1, 2006: Your Total Compensation for purposes of benefits enrollment is calculated as follows:

1. Annual base pay: Annual base pay as of July 1, 2005, will be used for 2006 annual enrollment calculations.
2. Commissions paid from January 1-December 31 in the year prior to enrollment to capture an entire year of commissions paid. Commissions paid from January 1-December 31, 2004, will be used for 2006 annual enrollment calculations.
3. Cash bonus (other than the cash portion of any annual discretionary award package) paid in the period January 1-December 31 in the year prior to enrollment. Cash bonuses paid in the period January 1-December 31, 2004 (excluding the cash portion of the annual discretionary award package dated January 2004) will be used for 2006 annual enrollment calculation.
4. Annual discretionary award package dated in the year of enrollment (includes the following if applicable: cash bonus, Capital Accumulation Program [CAP] Basic Award, and, for employees with discretionary award packages valued at $500,000 and above, Supplemental CAP award). Annual discretionary award packages dated January 2005 will be used for 2006 annual enrollment calculations.

FOR GLOBAL WEALTH MANAGEMENT FINANCIAL CONSULTANTS AND GLOBAL CONSUMER GROUP FINANCIAL EXECUTIVES OF CBNA

In your first year of employment, your total compensation is considered to be $60,000. If you earned more than $60,000 at a previous employer in the prior year and want your insurance coverage to represent your prior earnings, you can, but don't have to, provide a copy of your previous year's Form W-2 Wage and Tax Statement to your HR representative within 30 days of your hire date. Providing a copy of your previous year's Form W-2 is optional.

If you do provide a copy of the form, your Basic Life insurance amount will be set at the higher amount (up to $200,000). However, your contributions toward medical coverage, Optional Gr. T. amount, and LTD benefits and contributions also will be based on the higher amount.

Once made, your decision whether to have your total compensation set at $60,000 or your actual amount is irrevocable.

COVERAGE CATEGORIES

Citigroup offers four coverage categories from which you may choose to enroll for medical and dental coverage:

- Employee only: Coverage for you only;
- Employee plus spouse/domestic partner: Coverage for you and your spouse/domestic partner only;
- Employee plus children: Coverage for you and your eligible children, including the eligible children of your domestic partner; and
- Employee plus family: Coverage for you, your spouse/domestic partner, your eligible children, and your domestic partner's eligible children.

You can change your coverage category during the annual enrollment period and within 31 days of a qualified change in status.

QUALIFIED CHANGES IN STATUS

You must report to Citigroup any change of status that affects your benefits within 31 days of the qualified event by following the process described under "How to report a qualified change in status event" below. Don't report qualified changes in status to your medical Plan. Your medical Plan must receive any status changes from Citigroup, not from you.

Depending on the event, you can enroll in or cancel your medical, dental, vision care, HCSA, and DCSA coverage. You also can increase or decrease the amount of your HCSA and DCSA.

Examples of qualified changes in status are:

- Your marriage, legal separation, or divorce;
- Meeting the eligibility to qualify as a domestic partner;
- The birth or adoption of a child;
- The loss of coverage eligibility for a dependent child who gets married, obtains a full-time job, or recovers from a disability;
- The loss of coverage under your spouse's/domestic partner's or other employer's plan;
- The death of a spouse/domestic partner or dependent child;
- The issuance of a Qualified Medical Child Support Order (QMCSO); and
- Relocation outside your medical and/or dental Plan's network area.

HOW TO REPORT A QUALIFIED CHANGE IN STATUS EVENT

You'll have 31 days from the date of the event to report a qualified change in status event and, if applicable, make changes to your and/or your dependent's coverage, if necessary. To add a newborn child to your coverage, you must do so within 31 days of the child's birth.

To add a dependent, report the name, date of birth, and Social Security number (if available) for each dependent you want to add or remove from your coverage. If a newborn doesn't yet have a Social Security number, you must report all other information within 31 days and add the Social Security number once you obtain it.

Even if you're already enrolled in Citigroup family medical and dental coverage, you must report a new dependent. Otherwise, your new dependent's claims won't be paid. Don't report the existence of a new dependent to your medical/dental Plan. Your Plan must receive the information from Citigroup, not from you.

When reporting a new dependent whom you wish to enroll in Citigroup coverage, you may have to change your coverage category. For example: You're enrolled in medical coverage under the "Employee only" category and then you get married. If you want to cover your new spouse, you must report information about your new spouse *and* change from the "Employee only" to the "Employee plus spouse" coverage category.

To report a change in status, and, if applicable, change your coverage category and benefits:

- Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option. From the Benefits Service Center main menu, choose the option to change your coverage for the current year. You can report most changes by following the prompts. However, you must speak with a representative to report a divorce or the death of a dependent.
- Visit Total Comp at Citigroup (once you have access) at **https://www.totalcomponline.com** and link to the Citigroup Benefits Web Site from the "Medical, Dental, and Vision" page.

CHANGE IN STATUS WORKSHEET

You can review the Change in Status Worksheet-Form 308B, which lists status events and the corresponding changes you can make to your benefits coverage for each event. To obtain a Change in Status Worksheet, visit the "Forms" section of the You@Citigroup site on Citigroup.net at **http://www.citigroup.net/human_resources/form.htm**. Instructions for the Change in Status Worksheet are on Form 308A.

DEADLINE TO REPORT QUALIFIED CHANGES IN STATUS

You must report or revise dependent information and change your/your dependent's coverage or coverage category within 31 days of the qualified change in status event. Otherwise, you won't be able to change your coverage/dependent's coverage or coverage category until the next annual enrollment period or until you have another qualified change in status, whichever comes first.

PLAN CHANGES YOU CAN MAKE AT ANY TIME

You can cancel, enroll in, or change the following coverage at any time.

- LTD: You can enroll at any time but you must provide evidence of good health. However, unless you were enrolled in a prior employer's group plan three months prior to your hire date at Citigroup, the disability Plan won't cover any total disability caused by, contributed to, or resulting from a pre-existing condition until you've been enrolled in the Plan for 12 consecutive months. A pre-existing condition is an injury, sickness, or pregnancy for which — in the three months prior to the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.
- Optional GUL/AD&D: For the GUL portion of the benefit, MetLife will require evidence of good health if you want to:
  - Enroll for the first time (other than during your initial enrollment period as a new hire or newly eligible for Citigroup benefits) or
  - Increase your coverage amount.

Note: CIGNA administers the AD&D portion of the benefit and doesn't require evidence of good health.

- Long-Term Care insurance: You can enroll at any time; John Hancock will require evidence of good health before coverage will be approved.
- TRIP: You can enroll or change your contribution at any time. Changes are effective the first of the following month.

DOMESTIC PARTNER BENEFITS

Citigroup offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. You may cover your domestic partner and his or her eligible children under the following Plans:

- Medical, though some HMOs don't cover domestic partners or their children, see below for a list of the HMOs that won't cover domestic partners in 2006;
- Dental;
- Vision care;
- Health Care Spending Account, provided your domestic partner and his or her eligible children are considered tax dependents under Section 152 of the IRC;
- Optional GUL/Supplemental AD&D insurance for domestic partners and life insurance for children; and
- Long-Term Care insurance.

You may enroll your domestic partner and his or her eligible children in the medical and/or dental Plan in which you enroll. You may enroll your domestic partner in spouse GUL/AD&D insurance, Long-Term Care insurance, and/or the Vision Care Plan even if you don't enroll in those Plans.

The following HMOs won't cover domestic partners in 2006:

- Presbyterian Health Plan (NM) and
- Prevea Health Plan (WI).

All other HMOs cover domestic partners. For more information about HMO coverage for domestic partners, call the HMO at the telephone number on the HMO information sheet.

Note: None of the Citigroup medical options has a pre-existing condition limitation or exclusion that would prevent you from enrolling your domestic partner in the Plan or from your domestic partner receiving benefits for a specific condition or illness.

WHEN YOU CAN ENROLL YOUR DOMESTIC PARTNER IN CITIGROUP COVERAGE

You can enroll your domestic partner and his or her eligible children for Citigroup benefits during annual enrollment (for coverage effective January 1 of the following year) or within 31 days of a qualified change in status. Examples of qualifying events that'll allow you to enroll your domestic partner and his or her eligible children are:

- Upon completing a Certification of Domestic Partnership form, available through the Benefits Service Center; call the Benefits Service Center as instructed on page 4;
- The birth or adoption of a child; and
- Your domestic partner's loss of benefits coverage in another employer's plan.

ELIGIBILITY

You're eligible to enroll your domestic partner in Citigroup coverage if you're a U.S. employee who's active or on an approved leave of absence. However, if you're not actively at work, you can't enroll your domestic partner in Long-Term Care insurance.

To be eligible for coverage, you and your partner may be of the same or opposite sex, and both of you must meet the following criteria:

- You currently share a principal residence and intend to do so permanently;
- You've lived together for at least six consecutive months prior to enrollment;
- You're financially interdependent, or your partner is dependent on you for financial support;
- Neither you nor your domestic partner is legally married to another person;
- Both of you are at least 18 years old and mentally competent to consent to contract;
- You aren't related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;
- Neither you nor your domestic partner is in a domestic partnership with anyone else;
- You've mutually agreed to be responsible for each other's common welfare; and
- You're in a relationship intended to be both permanent and one in which each is the sole domestic partner of the other.

The children of your domestic partner are eligible for coverage if they:

- Are the biological or adopted children of your domestic partner, children for whom your domestic partner has legal guardianship, or children who've been placed in your home for adoption, and
- Are living with you and your domestic partner on a full-time basis or living away at school; and
  - Are under the age of 19[1]; or
  - Are under the age of 25[1] and are full-time students at an accredited school or college; (during enrollment each year, you'll be prompted to certify that your domestic partner's eligible child is a student even though you may not be changing medical Plans; you also must provide proof of student status in writing upon request); or
  - Were covered under the Plans before age 19, or age 25 as full-time students, and they become incapable of self-sustaining employment due to a disability, in which case they may be eligible for coverage beyond such age.

COST OF DOMESTIC PARTNER BENEFITS

If your domestic partner and his or her children:

- **Qualify** as your dependents under Section 152 of the IRC, your contributions for domestic partner medical, dental, and/or vision care coverage will be deducted from your pay before taxes are withheld.
- **Don't qualify** as dependents under Section 152 of the IRC, you'll pay for their medical, dental, and/or vision care coverage with after-tax dollars.

Tax implications

According to federal tax law, your taxes may be affected when you enroll your domestic partner in Citigroup coverage. This book doesn't address state and local tax treatment. For information on how applicable tax law may apply to your personal situation, consult your tax adviser.

If your domestic partner *doesn't* qualify as a dependent for tax purposes

Generally, medical, dental, and vision care aren't taxable benefits if they're provided to you, your spouse, or your dependents. However, if your domestic partner and your partner's children don't qualify as your dependents for income tax purposes, the value of their coverage is considered income to you.

[1] Coverage will remain in effect through December 31 of the year in which the child becomes ineligible for terms 25

This additional income, known as "imputed income," will be shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. You'll be required to pay taxes on this additional income, as required by the IRS.

If your domestic partner qualifies as a tax dependent

If your domestic partner and his or her children qualify as dependents under Section 152 of the IRC, your contributions for their medical, dental, and/or vision care coverage will be deducted from your pay before taxes are withheld, and there are no tax implications for you. Since requirements are complex, consult your tax adviser.

Generally, a member of your household qualifies as your tax dependent under the IRC if:

- You provide more than 50% of his or her financial support;
- He or she lives with you for the entire year; and
- He or she is a citizen or resident of the United States.

MATERNITY BENEFITS

Group health plans and health insurance issuers (including HMOs) generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally doesn't prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Reminder: To cover a newborn under your Citigroup medical/dental coverage, you must notify Citigroup within 31 days of the child's birth. See "How to report a qualified change in status event" on page 12.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans and HMO options provide this coverage.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you'll also be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymph edema.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a participant under a Citigroup Medical Plan or Citigroup Dental Plan who's an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the medical and dental Plans.

In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child, for example, in the case of a divorce or separation.

Call the Plan Administrator to receive, at no cost, a detailed description of the procedures for a QMCSO. However, if you have a question about filing a QMCSO, call the Benefits Service Center as instructed on page 4. You can file your QMCSO by mailing it to:

Citigroup QMCSO Administration
P.O. Box 56757
Jacksonville, FL 32241-6757.

HOW TO FILE A CLAIM

NAME OF CLAIMS ADMINISTRATOR OR PLAN	NAME/NUMBER OF FORM	USE THE FORM TO	HOW TO OBTAIN A FORM
Aetna	Aetna Medical Benefits Request-Form 301	File a claim for a covered out-of-network expense.	Visit the "Forms" section of You@Citigroup at **http://www.citigroup.net/human_resources/**. Visit the "health and welfare" section of **https://mybenefits.csplans.com**.
Empire BlueCross BlueShield	Health Insurance Claim Form for the ChoicePlans and Health Plan 2000-Form 322 Health Insurance Claim Form for the Out-of-Area Health Plan-Form 323	File a claim for a covered out-of-network expense.	
CIGNA	CIGNA Medical Claim Form-Form 302	File a claim for a covered out-of-network expense.	
UnitedHealthcare	Citigroup Health Claim Transmittal-Form 303	File a claim for a covered out-of-network expense.	
Express Scripts	Call Express Scripts at 1-800-227-8338 or visit **http://www.express-scripts.com**.		
Delta Dental	Delta Dental Claim Form-Form 307	File a claim for a covered out-of-network expense.	
MetLife Dental	MetLife Dental Claim Form-Form 304	File a claim for a covered dental expense.	
Health Care Spending Account	If you don't use your Citigroup FlexDirect debit card, you can file a claim using the HCSA Claim Form-Form 316. However, you may be asked to complete and return the Spending Account Expense Substantiation Form-Form 318 if ADP (the Claims Administrator) can't substantiate a transaction applied to your Citigroup FlexDirect debit card.	Submit eligible health care claims for reimbursement.	

HOW TO FILE A CLAIM (CONT'D.)

NAME OF CLAIMS ADMINISTRATOR OR PLAN	NAME/NUMBER OF FORM	USE THE FORM TO	HOW TO OBTAIN A FORM
Dependent Care Spending Account	If you don't use your Citigroup FlexDirect debit card, you can file a claim using the DCSA Claim Form-Form 317. However, you may be asked to complete and return the Spending Account Expense Substantiation Form-Form 318 if ADP (the Claims Administrator) can't substantiate a transaction applied to your Citigroup FlexDirect debit card.	Submit eligible dependent care claims for reimbursement.	Visit the "Forms" section of You@Citigroup at **http://www.citigroup.net/human_resources/**. Visit the "health and welfare" section of **https://mybenefits.csplans.com**.
Transportation Reimbursement Incentive Program (TRIP)	If you don't use your Citigroup FlexDirect debit card, you can file a claim using the Transportation Reimbursement Incentive Program Claim Form-Form 306. However, you may be asked to complete and return the Spending Account Expense Substantiation Form-Form 318 if ADP (the Claims Administrator) can't substantiate a transaction applied to your Citigroup FlexDirect debit card.	Submit eligible transit and/or parking expenses for reimbursement.	
HMO	Forms available from the HMO; contact your HMO directly.		

All claims for benefits must be filed within certain time limits.

- Medical, dental, and vision care claims must be filed within two years of the date of service.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA claims must be filed by June 30 of the calendar year following the year in which the expense was incurred. You can apply claims incurred from January 1, 2006-March 15, 2006, to your 2005 balance.
- DCSA claims must be filed by June 30 of the calendar year following the year in which the expense was incurred.
- TRIP claims must be filed within 12 months of the date on which the expense was incurred.

GLOSSARY

Care coordination: The Care Coordination Program through UnitedHealthcare was designed to encourage the identification and follow-up of the participant's covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management programs. Call UnitedHealthcare at 1-877-311-7845 for more information.

Coinsurance: The portion of a covered expense that you pay after you've satisfied the deductible. For example, if a Plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

Covered expenses: Medical and related costs, incurred by participants, that qualify for reimbursement under the terms of the insurance contract.

Deductible: The amount of eligible expenses you and each covered dependent must pay each calendar year before a plan begins to pay benefits.

Health Insurance Portability and Accountability Act (HIPAA): A U.S. law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost.

The law protects employees — especially those with long-term health conditions who may be reluctant to leave jobs because they're afraid that pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan — from losing health insurance due to a change in employment status. See the HIPAA section beginning on page 76.

Medically necessary: A service or supply is considered medically necessary if it's a generally accepted health care practice and is required to treat your condition, as determined by the Claims Administrator.

Notification: A requirement that a participant call his or her health plan to coordinate any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting. Call your Plan for more information.

Out-of-pocket maximum: Total payments (i.e., deductibles and coinsurance) toward eligible expenses that a covered person pays for himself or herself and/or dependents as defined by the contract.

Once the maximum out-of-pocket amount has been met, the Plan will pay 100% of reasonable and customary (R&C) charges. If the expenses incurred are higher than the R&C amount, the individual receiving the service is responsible for paying the difference even if the out-of-pocket maximum has been reached.

Precertification: A requirement that a participant call his or her health Plan before seeking certain treatment. The Plan will:

1. Help the participant and his/her health care provider determine the best course of treatment based on the diagnosis and acceptable medical practice and
2. Determine whether certain covered services and supplies are medically necessary.

No benefit will be paid for services that aren't considered medically necessary.

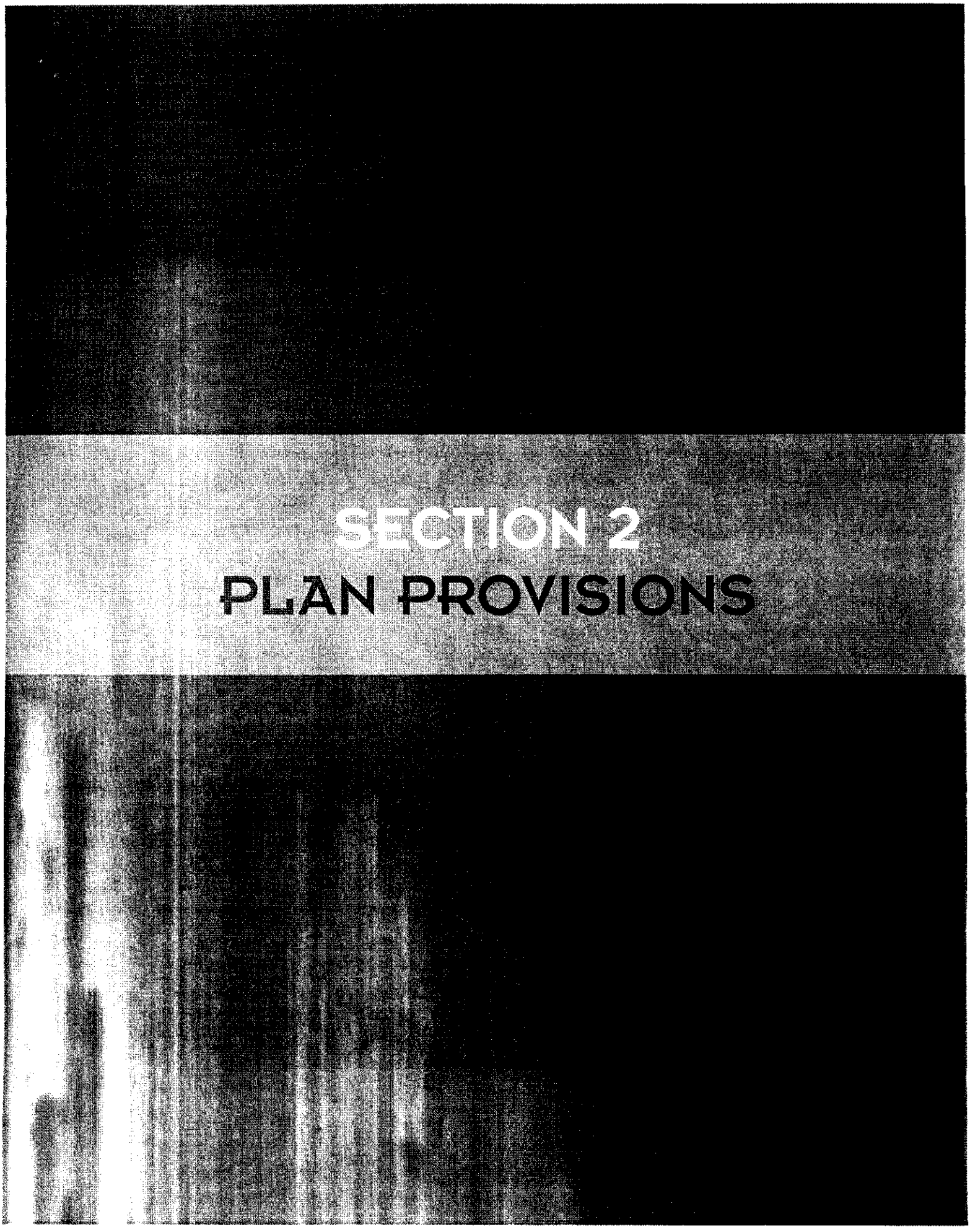
Pre-existing condition: An injury, sickness, or pregnancy for which — in the three months before the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

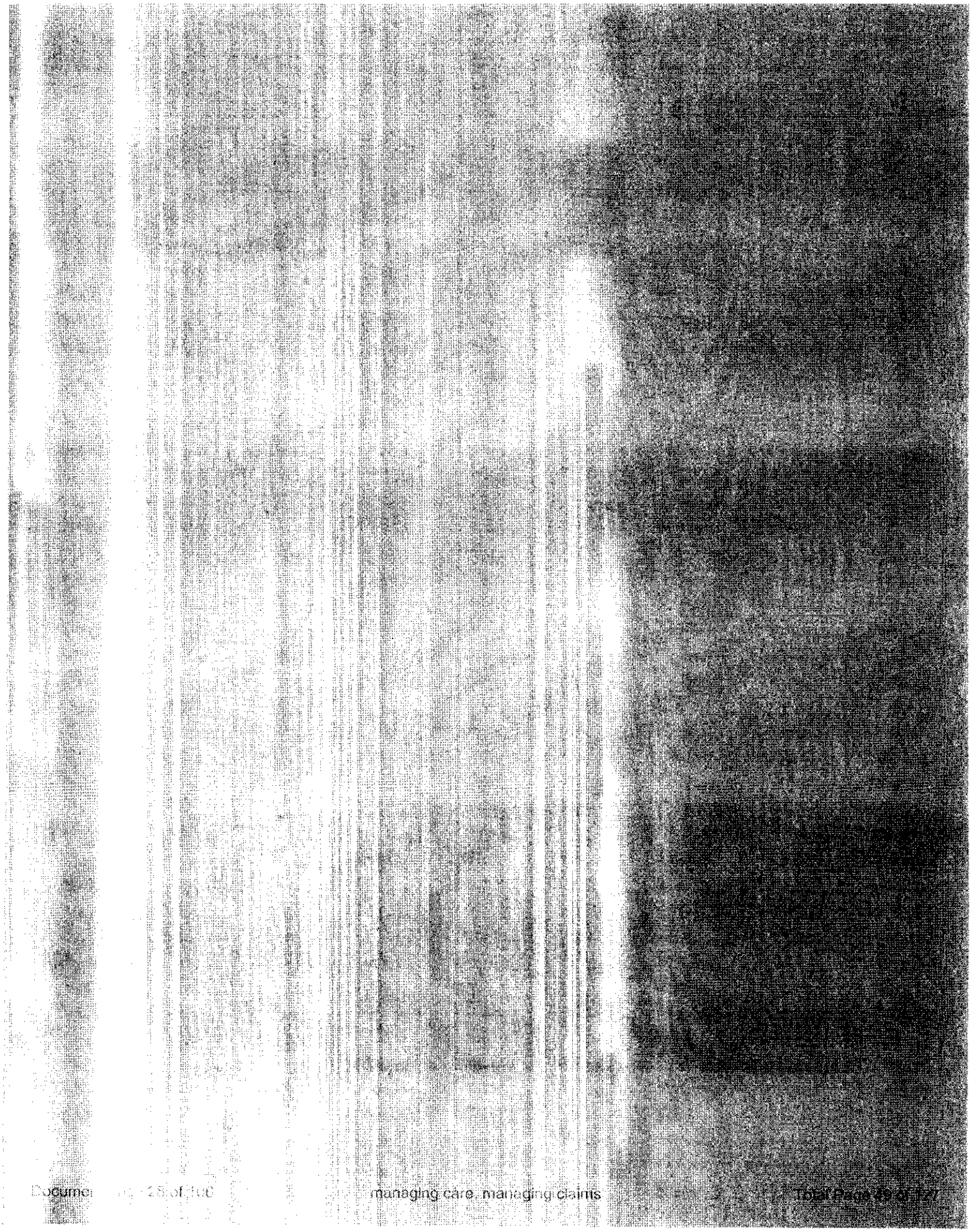
Preventive care: Routine care examinations based on guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams) and immunizations. See "Preventive care" on page 28.

Reasonable and customary charge (R&C): Any charge that, for services rendered by or on behalf of a network provider, doesn't exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule. As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Wellness services: Charges for routine care examinations based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams) and immunizations.


SECTION 2
PLAN PROVISIONS



MEDICAL

The following information applies to all Citigroup medical options except HMOs. If you're interested in HMO coverage, see the HMO details on the information sheets that are available on the Citigroup Benefits Web Site or accompany your Personal Enrollment Worksheet.

Citigroup offers HMOs and the following non-HMO Plans:

- ChoicePlan 100;
- ChoicePlan 250;
- ChoicePlan 500;
- HealthPlan 2500;
- Hawaii Health Plan; and
- Out-of-Area Health Plan (available only if you live in an area where a ChoicePlan isn't available)

The Citigroup Benefits Web Site and Personal Enrollment Worksheet list the medical options available to you based on your home zip code.

CHOICEPLAN ADMINISTRATORS

The ChoicePlan is administered by Aetna, CIGNA, Empire BlueCross BlueShield, and UnitedHealthcare. In some states, you'll have a choice between administrators; in other states, Citigroup has designated only one administrator. The ChoicePlan design is essentially the same no matter which company administers the Plan. Exceptions are noted.

A summary of all the non-HMO Plans follows.

MEDICAL OPTIONS AT A GLANCE

For HMO/EPO information, see the HMO/EPO information sheets.

	CHOICEPLAN 100 CHOICEPLAN 250 CHOICEPLAN 500 See your personal enrollment information for the name(s) of the administrator(s) in your area		HEALTH PLAN 2000 See your personal enrollment information for the name(s) of the administrator(s) in your area
	NETWORK	OUT OF NETWORK*	
ANNUAL DEDUCTIBLE (IN AND OUT OF NETWORK COMBINED)			
• Individual	Plan 100: $100 Plan 250: $250 Plan 500: $500	Plan 100: $300 Plan 250: $750 Plan 500: $1,500	$2,000
• Maximum per family	Plan 100: $200 Plan 250: $500 Plan 500: $1,000	Plan 100: $1,000 Plan 250: $1,500 Plan 500: $2,000	$4,000
OUT-OF-POCKET EXPENSE INCLUDES DEDUCTIBLE (IN AND OUT OF NETWORK COMBINED)			
• Individual	Plan 100: $2,000 Plan 250: $2,500 Plan 500: $3,000	Plan 100: $4,000 Plan 250: $5,000 Plan 500: $6,000	$5,000
• Maximum per family	Plan 100: $4,000 Plan 250: $5,000 Plan 500: $6,000	Plan 100: $8,000 Plan 250: $10,000 Plan 500: $12,000	$10,000
• Lifetime maximum	None	None	None
PHYSICIAN OFFICE VISITS			
• Doctor/primary care physician (PCP) visits	90% after deductible	70% after deductible	80% after deductible when using network providers; 70% after deductible when using out-of-network providers
• Specialist visits	90% after deductible	70% after deductible	
PREVENTIVE CARE, SUBJECT TO FREQUENCY LIMITS			
• Well adult	100% no deductible up to $250 maximum, then covered at 90%; benefits apply to in and out of network combined	100% no deductible up to $250 maximum, then covered at 70%; benefits apply to in and out of network combined	100% no deductible up to $250 maximum, then covered at 80% when using network providers and 70% when using out-of-network providers
• Well child and immunizations	100% no deductible up to $250 maximum, then covered at 90% Immunizations covered at 100%, no deductible	100% no deductible up to $250 maximum, then covered at 70% Immunizations covered at 70%, no deductible	100% no deductible; not subject to $250; includes immunizations
• Cancer screenings (PAP test, mammography, sigmoidoscopy, colonoscopy, PSA screening)	100% no deductible; not subject to $250	100% no deductible up to $250 maximum, then covered at 70%	100% no deductible, not subject to $250 when using network providers; 100% no deductible up to $250 maximum, then covered at 70% when using out-of-network providers

*All out-of-network reimbursements and maximums are based on reasonable and customary charges, as determined by the Plan. Contact the Plan for details.

HAWAII HEALTH PLAN Administered by UnitedHealthcare	OUT-OF-AREA HEALTH PLAN Administered by Empire BlueCross BlueShield (available only in an area where a ChoicePlan isn't available)
ANNUAL DEDUCTIBLE (IN AND OUT OF NETWORK COMBINED)	
$200	$300
$600	$900
OUT-OF-POCKET MAXIMUM (ALL YOUR DEDUCTIBLE IN AND OUT OF NETWORK COMBINED)	
$1,000	$1,000
$2,000	$2,000
$3 million	None
PROFESSIONAL CARE (IN OFFICE)	
90% after deductible when using network providers; 80% after deductible when using out-of-network providers	80% after deductible 80% after deductible
PREVENTIVE CARE, SUBJECT TO FREQUENCY LIMITS	
80% no deductible	100% no deductible up to $250 maximum, then covered at 80%
80% no deductible	100% no deductible, not subject to $250 maximum
80% no deductible	100% no deductible, not subject to $250 maximum

PLAN PROVISIONS

MEDICAL OPTIONS AT A GLANCE

For HMO/EPO information, see the HMO/EPO information sheets

	CHOICEPLAN 100 CHOICEPLAN 250 CHOICEPLAN 500 See your personal enrollment information for the name(s) of the administrator(s) in your area		HEALTH PLAN 2000 See your personal enrollment information for the name(s) of the administrator(s) in your area
	NETWORK	OUT OF NETWORK*	
HOSPITAL EMERGENCY ROOM			
No coverage in any medical option if not a true emergency	$50 copayment, waived if admitted within 24 hours of emergency room use	$50 copayment, waived if admitted within 24 hours of emergency room use	80% after deductible
URGENT CARE CENTER			
	90% after deductible	90% after deductible; 70% after deductible for BlueCross BlueShield participants	80% after deductible when using network providers; 70% after deductible when using out-of-network providers
HOSPITAL INPATIENT AND OUTPATIENT			
Some services (such as physicians' charges, lab, x-ray)	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	80% after deductible when using network facilities; 70% after deductible when using out-of-network facilities; notification required for hospitalization, facility admissions, and certain outpatient procedures
INFERTILITY			
Expenses are covered in and out of network combined; deductible and coinsurance apply to all covered services	Up to a $25,000 lifetime medical maximum and a $7,500 lifetime pharmacy maximum per family		
MENTAL HEALTH AND SUBSTANCE ABUSE			
• Inpatient Maximum of 30 days per calendar year in and out of network combined Coinsurance doesn't apply to out-of-pocket maximum	90% after deductible if you call your plan and use in-network providers or facilities	70% after deductible; precertification required	80% after deductible when using network providers; precertification required; 70% after deductible when using out-of-network providers; precertification required
• Outpatient Maximum of 52 visits per calendar year, except for Hawaii Health Plan (50 visits per year) in and out of network combined Coinsurance doesn't apply to out-of-pocket maximum	90% after deductible if you call your plan and use network providers or facilities	50% after deductible	80% after deductible when using network providers or facilities; 50% after deductible when using out-of-network providers

*All out-of-network terms, services and maximums are based on reasonable and customary charges as determined by the Plan. Contact the Plan for details.

HAWAII HEALTH PLAN Administered by HMSA/Healthcare	OUT-OF-AREA HEALTH PLAN Administered by Empire BlueCross BlueShield (available only in an area where a ChoicePlan isn't available)
HOSPITAL EMERGENCY ROOM	
90% after deductible for doctor; 80% after deductible for hospital	80% after deductible
URGENT CARE CENTER	
90% after deductible when using network providers for 80% of reasonable and customary charges after deductible when using out-of-network providers	80% after deductible
HOSPITAL INPATIENT/OUTPATIENT	
90% for doctor fee when using network doctors; 80% after deductible when using out-of-network doctors; 60% after deductible when using network hospitals; 80% after $100 confinement deductible and calendar-year deductible when using out-of-network hospitals; notification required for hospitalization and certain outpatient procedures	80% after deductible; notification required for hospitalization, facility admissions, and certain outpatient procedures
LIFETIME	
Up to a $25,000 lifetime medical maximum and a $7,500 lifetime pharmacy maximum per family	
MENTAL HEALTH/SUBSTANCE ABUSE	
80% after deductible when using network providers; precertification required; 50% after deductible plus $100 confinement deductible when using out-of-network providers; precertification required	80% after deductible; precertification required
80% after deductible for all out-of-network combined; precertification required	50% after deductible; precertification required

Quick tip: Use the Health Care Spending Account to save money on your out-of-pocket health care expenses. You can contribute up to $8,000 in pre-tax dollars to pay for your deductibles, copayments, coinsurance, and other eligible medical, dental, and vision care expenses that aren't paid by any plan. You'll forfeit any money remaining in the account for which you haven't submitted a claim by the filing deadline.

PREVENTIVE CARE

Preventive care services are available in the ChoicePlan, Health Plan 2000, the Hawaii Health Plan, and the Out-of-Area Health Plan.

Annual allowance: In all Plans except the Hawaii Health Plan, each participant has a $250 annual allowance toward routine periodic exams in and out of network combined.

In the Hawaii Health Plan, routine physical exams and well-woman exams are covered at 80% with no deductible to meet. Well-child exams and immunizations are covered at 50% with no deductible to meet.

Cancer screenings and well-child immunizations: In all Plans except the Hawaii Health Plan, both cancer screening tests and well-child immunizations performed by network providers are covered at 100% and aren't subject to the $250 annual allowance. For more details, see pages 24-25.

Preventive care services include:

- Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis and immunizations excluding travel immunizations for participants in all but the Aetna non-HMO plans, which do cover travel immunizations;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

Cancer screening tests are:

- PAP smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy; and
- PSA test.

CHOICEPLAN

In a ChoicePlan, you choose whether to use network or out-of-network providers each time you need treatment. You must meet a deductible both in and out of the network before the Plan will pay benefits. Precertification is required before any inpatient hospital stay and certain outpatient procedures.

ChoicePlan network features:

- When you visit a network provider, you don't have any claim forms to complete.
- The ChoicePlan has no lifetime maximum benefit.
- You'll pay a network deductible for all services — with the exception of the $250 preventive care allowance — before the Plan will pay benefits. Once you meet your network deductible, the Plan will pay 90% of covered charges while you'll pay 10% of covered charges up to your annual out-of-pocket maximum. Any amounts that count toward the network deductible also count toward the out-of-network deductible.
- Preventive care: Preventive care and periodic exams for adults and children are covered at 100% up to $250 per person (in and out of network combined), then at 90%; immunizations and cancer screenings are covered at 100% when performed by network providers.
- If you visit an allergist for allergy injections, once you meet your deductible you'll pay your coinsurance for your first office visit. For each additional injection for which you aren't charged for an office visit, injections will be covered at 100% and the coinsurance will be waived.

CHOOSING A NETWORK PROVIDER

You can visit your ChoicePlan's Web site to review its list of providers. When you're prompted to enter the name of your Plan, enter the name below:

- Aetna: Open Choice Preferred Provider Organization;
- CIGNA: Open Access Plus network;
- Empire BlueCross BlueShield: PPO/EPO for ChoicePlan and Health Plan 2000; Traditional/Indemnity for the Out-of-Area Plan; or
- UHC: Choice Plus Plan.

ChoicePlan network features

- You must file a claim to be reimbursed for covered expenses. See "How to file a claim" on page 18.
- The ChoicePlan has no lifetime maximum benefit.
- Other than for preventive care services, you must meet an annual deductible before the ChoicePlan will pay benefits. The network deductible also counts toward the out-of-network deductible.
- Most covered expenses are reimbursed at 70% of reasonable and customary charges after the annual deductible is met.
- You must notify your Plan before undergoing certain procedures and services, according to your Plan's rules, or you may pay a penalty. In the ChoicePlans administered by Aetna, Empire BlueCross BlueShield, and CIGNA, the process is known as "precertification." In the ChoicePlan administered by UHC, the process is called "care coordination." See "Precertification" on page 32 or "Care coordination" on page 33.

Multiple surgical procedure guidelines

If you're using an out-of-network provider for a surgical procedure, the following multiple surgical procedure guidelines will apply.

If more than one procedure will be performed during one operation — through the same incision or operative field — the Plan will pay according to the following guidelines:

- Primary procedure: The Plan will allow 100% of the negotiated or reasonable and customary fee.
- Secondary procedure: The Plan will allow 50% of the negotiated or reasonable and customary fee.
- Tertiary and additional procedures: The Plan will allow 50% of the negotiated or reasonable and customary fee for each additional procedure.
- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or reasonable and customary fee for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or reasonable and customary fee for tertiary/additional procedures.

If billed separately, incidental surgeries won't be covered. An incidental surgery is a procedure performed at the same time as a primary procedure and requires little additional physician resources and/or is clinically an integral part of the performance of the primary procedure.

Paying your bill at your network doctor's office

After you meet your annual deductible, the Plan will pay 90% for most covered services, while you'll pay 10% of the Plan's negotiated rate. In most cases, you'll be billed by your doctor for the 10%. Generally, you won't pay your network doctor on the day of your visit because you'll have to wait for your portion of the charge to be calculated.

HEALTH PLAN 2000, HAWAII HEALTH PLAN, AND OUT-OF-AREA HEALTH PLAN

All three Plans cover the same wide range of services, including preventive care features. You'll find the name of the administrator on your health plan information sheet.

Network providers

You can save money by using network providers who agree to charge discounted fees to members. When you use a network provider, most covered expenses are covered at 80% or 90% of the negotiated fee after the annual deductible is met. See the chart on pages 23-27.

You can find the names of network providers by visiting the Plan's Web site or calling the vendor that administers the Plan.

- **Aetna:** Visit **http://www.aetna.com**, or call 1-800-545-5862. When prompted to choose a network, choose the "Open Choice Preferred Provider Organization."
- **Empire BlueCross BlueShield:** Visit **http://www.empireblue.com**, or call 1-866-290-9098. When prompted to choose a network:
  - For Health Plan 2000, enter "PPO/I PO."
  - For the Out-of-Area Health Plan, enter "Traditional/Indemnity."
- **CIGNA:** Visit **http://www.cigna.com**, or call 1-800-794-4953. When prompted to choose a network, choose "Open Access Plus."
- UHC: Visit **http://www.provider.uhc.com/citigroup**, or call 1-877-311-7845. When prompted to choose a network, choose "Choice Plus Plan."

Health Plan 2000 features

- Other than for preventive care benefits, you must meet an annual $2,000 individual deductible ($4,000 family) before the Plan will pay benefits.
- Your annual individual out-of-pocket maximum, including the deductible, is $5,000 ($10,000 family).
- Most eligible expenses are reimbursed at 80% of the negotiated fee after the annual deductible has been met. Covered expenses for claims submitted by an out-of-network provider are reimbursed at 70% of reasonable and customary charges.
- You must file a claim to be reimbursed for covered expenses. Empire BlueCross BlueShield participants don't need to file claims for services from a network provider.
- The Plan has no lifetime maximum benefit.

Hawaii Health Plan features

- You must meet an annual $200 individual deductible ($600 family) before the Plan will pay benefits.
- Your annual individual out-of-pocket maximum, including the deductible, is $1,000 ($2,000 family).
- Most covered network expenses are reimbursed at 90% of reasonable and customary charges after the annual deductible has been met. Claims submitted by an out-of-network provider are reimbursed at 80%.
- Routine physical exams and well-woman exams are covered at 80% with no deductible to meet.
- Well-child-care exams and immunizations are covered at 80% with no deductible to meet.
- The Plan has a $3 million lifetime maximum benefit.

Out-of-Area Health Plan features

Administered by Empire BlueCross BlueShield; available only in areas where there's no ChoicePlan offered.

- Other than for preventive care benefits, you must meet an annual $300 individual deductible ($600 family) before the Plan will pay benefits.
- Your annual individual out-of-pocket maximum, including the deductible, is $1,000 ($2,000 family).
- Most eligible expenses are reimbursed at 80% of what Empire BlueCross BlueShield considers the reasonable and customary fee after the annual deductible has been met.
- The Plan has no lifetime maximum benefit.

Filing a claim

See "How to file a claim" on page 18.

ADDITIONAL MEDICAL PLAN INFORMATION

These features apply to ChoicePlan 100, 250, and 500; the Hawaii Health Plan; Health Plan 2000; and the Out-of-Area Health Plan, as noted.

NATIONAL ADVANTAGE PROGRAM (NAP)

NAP is available to Aetna participants using out-of-network services. By using NAP, you have access to discounted rates for many hospital and doctor claims that would otherwise be paid as billed or for emergency/medically necessary services that aren't provided in the Aetna network. For more information, call Aetna at 1-800-545-5862.

SHARED SAVINGS PROGRAM

This program is available to UHC participants in non-HMO Plans.

By using an out-of-network provider, your out-of-pocket costs generally will be higher than when you use a network provider.

However, by using a provider available through UHC's Shared Savings Program, your claim will still be paid at the out-of-network level, but a discounted rate will be used to determine the amount of your out-of-pocket cost. In addition, Shared Savings providers won't collect the portion of billed charges that exceeds the discounted rate.

Once enrolled in a Plan administered by UHC, visit **https://www.myuhc.com** for information about the Shared Savings Program and for the names of participating providers.

INFERTILITY

All non-HMO medical options cover the medical and pharmacy expenses associated with infertility treatment. The medical infertility treatment includes in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/investigational treatments.

If both you and your spouse/domestic partner are enrolled in Citigroup coverage, both of you are eligible for one lifetime maximum benefit under the infertility provision. You aren't eligible for one lifetime maximum benefit each.

The infertility benefit covers:

- Prescription drug expenses (managed by Express Scripts) associated with infertility treatment up to a $7,500 lifetime maximum for participants and
- Medical expenses up to a $24,000 lifetime maximum across all non-HMO Plans in and out of network combined.

For the donor, the Plan covers the cost of physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor; all office visits; ultrasound; lab work normally done on the Plan participant; and the harvesting of her eggs.

The lifetime maximum per person can be spent in one year or over a number of years. If you change non-HMO medical options, the Plan administrators will keep track of the amount you have remaining toward this benefit.

Call your Plan if you have questions about specific procedures or treatments.

Note: HMOs may offer different infertility coverage; check your HMO information sheet for details.

CANCER RESOURCE SERVICES

For participants enrolled in any medical option administered by UHC (including UHC HMOs).

UHC's Cancer Resource Services can assist when you or a covered dependent is diagnosed with cancer and must make difficult and important decisions such as what kind of treatment to get and where to get treatment.

In addition to helping you answer these questions, the Cancer Resource Services unit also can arrange for and coordinate access to a full range of comprehensive cancer treatment services provided by UHC's network of cancer "centers of excellence." Centers of excellence cancer centers provide:

- Comprehensive, highly specialized teams of experts with extensive experience in cancer diagnosis and treatment, including rare cancers;
- Second-opinion services if you're unsure about your diagnosis or what treatment is right for you;
- Experience in performing a large number of cancer surgeries and other complex procedures; and
- Access to new experimental treatments that may be an option for some patients.

To learn more about Cancer Resource Services, call 1-866-936-6002 from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays, or visit the Cancer Resources Web site at **http://www.urncrs.com**.

You aren't charged for this service, and you have no obligation to use a Cancer Resource Services cancer center.

NATIONAL MEDICAL EXCELLENCE PROGRAM®

For participants enrolled in any medical option administered by Aetna (including Aetna HMOs).

The National Medical Excellence® program can arrange for care when appropriate care isn't available in your local service area. Specifically, NMEP may coordinate the care for participants who need:

- Bone marrow or organ transplantation;
- "Investigational" or new technology (when standard care isn't available);
- Pre-authorized care that isn't available within 100 miles of a participant's home; or
- Emergency care while temporarily traveling outside the United States.

If your case is referred to NMEP, a case manager will work with your PCP or specialist to identify the best possible resources for care. Covered medical expenses will be paid according to your Plan.

In addition, the program will cover the cost of transportation and lodging for you and a companion if the facility to which you're directed is more than 100 miles from your home. The lodging expense maximum is $50 per night, and the travel and lodging maximum is $10,000. For details, contact the Member Services number on your medical plan ID card.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

The non-HMO Plans provide confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

When you call your medical Plan at the toll-free number on your medical ID card, you'll speak with an intake coordinator who'll help find the right care provider for you. In an emergency, the intake coordinator also will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility.

You must call your medical Plan before seeking treatment for non-emergency mental health or substance abuse. If you're enrolled in ChoicePlan 100, 250, or 500, you — not your PCP — must obtain referrals and precertification for this type of treatment.

PRECERTIFICATION

Precertification helps ensure that you obtain the most appropriate care for your condition. Requirements vary, so if you're enrolled in a ChoicePlan administered by Aetna, Empire BlueCross BlueShield, or CIGNA, review your Plan's precertification requirements below. UHC ChoicePlan participants should refer to the "Care Coordination" program section on page 33.

Precertification requirements for the ChoicePlan administered by Aetna and CIGNA

You must notify your Plan of a scheduled inpatient admission date at least 14 days prior to the date of admission. If you don't know your admission date at least 14 days prior to the date of admission, call your Plan as soon as the admission date is set.

You must call before:

- A scheduled hospital admission, including admission to a mental health or substance abuse treatment facility;
- A scheduled admission to a skilled nursing facility or hospice care facility;
- Receiving home health care; or
- Receiving private-duty nursing.

For outpatient services and diagnostic testing

You must notify your Plan at least five business days before receiving any of the services listed below.

- Breast reconstruction (other than following surgery for cancer) and breast reduction;
- Bunionectomy (surgical removal of a bunion);
- Hammertoe repair;
- Carpal tunnel surgery (surgical treatment of carpal tunnel syndrome);
- Colonoscopy (Aetna only);
- Coronary angiography (examination of vessels using radiographic imaging technology);
- CT scans of the spine (cross-sectional exam of the spine);
- Dilation and curettage (D&C) (surgical scraping of the uterus);
- Hemorrhoidectomy (surgical removal of hemorrhoids);
- Knee arthroscopy (interior examination of the knee joint);
- Laparoscopy (abdominal) (interior examination of the abdomen);

- MRI of the knee (examination of the knee using imaging technology);
- MRI of the spine (examination of the spine using imaging technology);
- Nasal endoscopy;
- Rehabilitation care;
- Rhinoplasty;
- Septoplasty (surgery of the nasal wall);
- Specialist-to-specialist referrals (CIGNA only);
- Tympanostomy (insertion of a tube in the middle ear);
- Upper eyelid surgery; and
- Upper gastrointestinal endoscopy (interior examination of the stomach and intestines).

Precertification for Care Coordination Plans administered by Empire BlueCross BlueShield

You're required to obtain precertification for both network and out-of-network services. Your network doctor doesn't obtain precertification on your behalf.

Your medical Plan reviews and determines whether hospitalization and non-emergency surgery are medically necessary.

In case of an unscheduled or emergency admission, you or your doctor must call your Plan within two business days after the admission.

When traveling outside the United States, you aren't required to obtain precertification for emergency hospitalization or other emergency services.

You're required to obtain precertification for the following services:

- Inpatient facility admissions, including emergency admissions and inpatient physical rehabilitation;
- Home health care services, including private-duty nursing;
- Hospice care;
- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
- Organ and tissue transplants;
- Admission to a skilled nursing facility; and
- Air ambulance.

Note about outpatient physical, occupational, and speech therapy: No precertification is needed. Treatment is limited to 60 visits to the above therapies combined. Additional visits aren't permitted.

No benefits are payable unless Empire BlueCross BlueShield determines that the services and supplies are covered under the Plan.

CARE COORDINATION PROGRAM

For non-HMO Plans administered by UHC.

UHC's Care Coordination Program is designed to encourage the identification and follow-up of your covered health care needs. Care Coordination activities aren't a substitute for the medical judgment of your doctor, and the ultimate decision of what medical care you or your covered dependents actually receive is left to you and your doctor.

No benefits are payable unless the services and supplies are covered under the Plan.

Care Coordination activities

Care Coordination is composed of these activities:

- **Notification:** Notification serves as the "gate" to other Care Coordination Program activities. You must call the UHC Care Coordination Program at 1-877-311-7845 if you're enrolled in a Plan administered by UHC and will require any of the following services:
  - Inpatient facility admissions, including emergency admissions;
  - Home health care services, including private-duty nursing;
  - Reconstructive procedures;
  - Hospice care;
  - Maternity (for notification purposes); you must call within the first trimester;
  - Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
  - Dental services (accident only);
  - Durable medical equipment with a retail cost of more than $1,000 whether for purchase or rental; and
  - Transplant services.
- **Admission Counseling:** A telephone process during which members will receive education about their upcoming admission.
- **Inpatient Care Advocacy:** A process to facilitate access to care for hospitalized participants. Care advocates will work with the doctor and hospital staff to assess

the participant's medical condition and plan of care to determine whether there are potential delays in service or whether another level of care may be more appropriate.

- **Welcome Home:** A program for participants who have a specific diagnosis following their discharge from the hospital. This program is designed to support a successful transition from the inpatient setting to the home.
- **Intervention:** An outpatient program to identify members at risk for declining health status. The program focuses on stabilizing outpatient care needs to prevent an avoidable readmission or gaps in the delivery of health care.

CITIGROUP PRESCRIPTION DRUG PROGRAM

When you enroll in ChoicePlan 100, 250, or 500, Health Plan 2000, the Hawaii Health Plan, or the Out-of-Area Health Plan, you'll have coverage in the Citigroup Prescription Drug Program, managed by Express Scripts.

Express Scripts offers two ways to purchase prescription drugs:

- A network of retail pharmacies nationwide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection, and
- Express Scripts Home Delivery through which you may save money by having your maintenance drugs delivered by mail.

You'll pay a deductible, as shown in the chart below, for drugs purchased at a retail pharmacy before the Plan will pay benefits.

C...GROUP PRESCRIPTION DRUG PROGRAM		
	Your costs under ChoicePlan 100, 250, or 500/Prescription Drug Plan A[1] (lower out-of-pocket costs; higher payroll deductions)	**Your cost under ChoicePlan 100, 250, or 500/Prescription Drug Plan B[2] (higher out-of-pocket costs; lower payroll deductions)**
Deductible (applies to drugs purchased at a retail pharmacy)	$50 per person/$100 family maximum	$100 per person/$200 family maximum
Copayment for up to a 34-day supply at a retail network pharmacy after meeting the deductible • Generic drug[3] • Preferred or formulary drug[4] • Non-preferred or non-formulary drug	 $10 $20 50% of the cost of the drug with a minimum payment of $40 to a maximum of $100	 $15 $30 50% of the cost of the drug with a minimum payment of $50 to a maximum of $100
Copayment for a 90-day supply through the Express Scripts Home Delivery program • Generic drug[3] • Preferred or formulary drug • Non-preferred or non-formulary drug	 $25 $50 50% of the cost of the drug with a minimum payment of $100 to a maximum of $250	 $35 $70 50% of the cost of the drug with a minimum payment of $100 to a maximum of $250
Benefits at an out-of-network pharmacy	You'll be reimbursed for 50% of your cost after filing a claim.	You'll be reimbursed for 50% of your cost after filing a claim.

[1] Pre... Plan A is provided as part of the Hawaii Health Plan and Out-of-Area Health Plan.

[2] Pre... Plan B is provided as part of Health Plan 2000.

[3] This ... that covers as many drugs as possible (through both the retail and Express Scripts Home Delivery programs) is more cost-effective. Ask your medical professional ... prescription.

[4] Cla... drugs. Rather, Express Scripts brings together an independent group of practicing doctors and pharmacists who meet quarterly to ... recommendations based on current clinical information. Call Express Scripts at 1-800-227-8338 for a copy of its Preferred Formulary ... at http://www.express-scripts.com

P[illegible] PRESCRIPTIONS

Re[illegible]

Wh[illegible] need a prescription filled the same day, for exam[illegible], an antibiotic to treat an infection, you can go to one [illegible] the thousands of pharmacies nationwide that participate in Express Scripts' network and obtain up to a 34-[illegible] supply for your copayment (once you meet your ded[illegible]tible).

To find out whether a pharmacy participates in the Exp[illegible] Scripts network:

- Ask [illegible] pharmacist.
- Vi[illegible] http://www.express-scripts.com, and use the on[illegible] pharmacy locator; or
- C[illegible] Express Scripts at 1-800-227-8338, and follow the pr[illegible]ts for the retail pharmacy locator.

A network pharmacy will accept your prescription and prescription drug ID card, and, once you've met your deductible, charge you the appropriate copayment/coinsurance for a covered drug. Your copayment/coinsurance will be based on whether you're enrolled in Prescription Drug Plan A or B and whether your prescription is for a generic drug, a preferred brand-name drug on Express Scripts Preferred Formulary, or a non-preferred brand-name drug.

Meeting your deductible

When you buy a prescription drug at a retail pharmacy, you must meet a deductible (single or family) before the Plan will pay benefits. Below are examples of how the deductible is calculated and the benefit paid.

H[illegible] DEDUCTIBLE WORKS

	PRESCRIPTION DRUG PLAN A	PRESCRIPTION DRUG PLAN B
E[illegible] example assumes you h[illegible] met your deductible and a[illegible] buying your drugs at a retail n[illegible]rk pharmacy. For copay-m[illegible] amounts, see the chart on pa[illegible] 33.	**Deductible is $50 per person and $100 maximum for a family.** **Your/your dependent's individual deductible amount won't exceed $50 each.**	**Deductible is $100 per person and $200 maximum for a family.** **Your/your dependent's individual deductible amount won't exceed $100 each.**
Example 1 Your preferred brand drug costs $[illegible]. Your spouse's preferred b[illegible] drug costs $150.	You pay $70 ($50 deductible + $20 copayment). Your spouse pays $70 ($50 deductible + $20 copayment). You've met both your individual ($50) and family ($100) deductibles. You'll pay only a copayment for each covered prescription drug purchased at a retail network pharmacy for the remainder of the year.	You pay $130 ($100 deductible + $30 copayment). Your spouse pays $130 ($100 deductible + $30 copayment). You've met both your individual ($100) and family ($200) deductibles. You'll pay only a copayment for each covered prescription drug purchased at a retail network pharmacy for the remainder of the year.

HOW THE DEDUCTIBLE WORKS (CONT'D.)		
	PRESCRIPTION DRUG PLAN A	PRESCRIPTION DRUG PLAN B
Example 3 You generic drug costs $ spouses generic drug costs $30.	You pay $60 ($50 deductible + $10 copayment). Your spouse pays $30 (cost of the drug). You've met your individual deductible ($50), and $80 ($50 + $30) has been applied to the family deductible of $100. The remaining $20 toward the family deductible will be applied when the next covered family member who hasn't met the individual deductible purchases a covered drug from a retail network pharmacy during the same year.	You pay $110 ($100 deductible + $10 copayment since you won't pay more than the cost of the drug). Your spouse pays $30 (cost of the drug). $130 ($100 + $30) has been applied to the family deductible. The remaining $70 toward the family deductible will be applied when the next covered family member who hasn't met the individual deductible purchases a covered drug at a retail network pharmacy during the same year.
E Y preferred drug co Your spouses n preferred drug costs $	You pay $150 ($50 deductible + $100 copayment, the maximum copayment under the Plan). Your spouse pays $115 ($50 deductible + $65 copayment, which is 50% of the balance). You've met both your individual ($50) and family ($100) deductibles. You'll pay only a copayment for each covered prescription drug purchased at a retail network pharmacy for the remainder of the year.	You pay $200 ($100 deductible + $100 copayment, the maximum copayment under the Plan). Your spouse pays $150 ($100 deductible + $50 minimum copayment). You've met both your individual ($100) and family ($200) deductibles. You'll pay only a copayment for each covered prescription drug purchased at a retail network pharmacy for the remainder of the year.

P[illegible] [illegible]PTION

H[illegible] DEDUCTIBLE WORKS (CONT'D.)

	PRESCRIPTION DRUG PLAN A	PRESCRIPTION DRUG PLAN B
E[illegible]	You pay $60 ($50 deductible + $10 copayment).	You pay $100 ($100 deductible, which is the cost of the drug).
Y[illegible] generic drug costs $150. Your s[illegible]'s generic drug costs $30. Y[illegible] generic drug costs $40.	Your spouse pays $30 ($30 applied to the family deductible).	Your spouse pays $30 ($30 applied to the family deductible).
	For your child's drug, you pay $30 ($20 applied to the family deductible + $10 copayment).	For your child's drug, you'll pay $40 ($40 applied to the family deductible).
	You've met both your individual ($50) and family ($100) deductibles.	You've paid $170 toward the family deductible.
	You'll pay only a copayment for each covered prescription drug purchased at a retail network pharmacy for the remainder of the year.	The remaining $30 toward the family deductible will be applied when the next covered family member who hasn't met the individual deductible purchases a covered drug at a retail network pharmacy during the same year.

Exp[illegible]ts Home D[illegible]y for maintenance dru[illegible]

For [illegible]n drugs you take over an extended period of t[illegible] as blood pressure medication, insulin, or thy[illegible]ones, you must use the Express Scripts Hom[illegible]y program to avoid paying 100% of the cos[illegible]

Th[illegible] Express Scripts [illegible]s Delivery program, you [illegible] up to a 90-day s[illegible]ply at one time. You'll mak[illegible] copayment for each prescription drug or refill, and y[illegible] cost will be less than what you'd pay to purchas[illegible] amount at a re[illegible] network pharmacy.

Wh[illegible] you use the Express Scripts Home Delivery pro[illegible]

- Y[illegible] tions are dispe[illegible] by one of Express S[illegible] Delivery pha[illegible]es and delivered to y[illegible]
- M[illegible] are shipped by [illegible]ndard delivery at no ad[illegible] cost to you. Expe[illegible] shipping is available for an[illegible] charge.
- You can order and track your refills online at **http://www.express-scripts.com**, or you can call Express Scripts at 1-800-227-8338 to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.

Controlled substances

Upon request, Express Scripts will fill prescriptions for controlled substances for up to a 90-day supply, subject to state law.

Because special requirements for shipping controlled substances may apply, Express Scripts uses only certain home delivery pharmacies to dispense these medications. If you submit a prescription for a controlled substance along with other prescriptions, it may need to be filled through a different pharmacy from your other prescriptions. As a result, you may receive your order in more than one package.

For [illegible] information about controlled substances and for [illegible] your state, call Express Scripts at 1-8[illegible].

If [illegible] maintenance medication. The [illegible] times you purchase a maintenance medication at a retail network pharmacy after you meet the deductible, you'll pay the retail network pharmacy copay. You'll also receive a notice from Express Scripts [illegible] you of the benefits of the Express Scripts Home Delivery program.

If, after [illegible] prescription is filled three times, you still want [illegible] your maintenance medication at a retail network pharmacy instead of through Express Scripts Home Delivery, you'll pay 60% of the cost. You'll also pay [illegible] the cost for any new prescriptions presented at a network pharmacy for the same drug.

P[illegible]

To [illegible] certain medications or to receive more than a certain [illegible] of some medications, your pharmacist must [illegible] "prior authorization" from Express Scripts before these drugs will be covered under the Citigroup Prescription Drug Program:

- [illegible] medications requiring "prior authorization" [illegible] Accutane, [illegible] Hormones, anti-obesity [illegible] and Botox.
- [illegible] medications [illegible] quantity will be limited [illegible] smoking cessation products, migraine medications, erectile dysfunction medications. Other [illegible] such as certain non-steroidal anti-inflammatories, will be covered only in situations [illegible] cost alternative medication isn't appropriate.

If your medication or its quantity requires approval before it can be dispensed, your pharmacist will let you know. If necessary, the pharmacist can ask your doctor to call [illegible] 5498. After your doctor provides the required information, Express Scripts will review your case [illegible] specialized [illegible] two business days. Once [illegible] is complete, Express Scripts will notify you [illegible] of the decision.

If your medication or the requested quantity isn't approved [illegible] coverage under the Citigroup Prescription Drug [illegible], you can purchase the drug at the full cost.

Once you're enrolled in a medical option that offers Express Scripts prescription drug coverage, you can check the price of a medication and whether it requires prior authorization by:

- Visiting **http://www.express-scripts.com**.
- Calling Express Scripts at 1-800-227-8338.

Changing your medication

On occasion, Express Scripts may contact your doctor with an opportunity to change your twice-a-day medication to a once-a-day strength of the same medication. So instead of 5 milligrams two times a day of a given medication you could take 10 milligrams once a day of the same medication (for some drug products).

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

HMOs encourage preventive care and provide services through the use of their networks.

The following features apply to most HMOs:

- You'll make a copayment for each doctor's office visit and for other services.
- For each inpatient stay in a hospital, you'll pay $500.
- For each treatment in an outpatient facility, such as outpatient surgery, you'll pay $200.
- Each HMO covers prescription drugs based on its own formulary list and benefit schedule.

If you're eligible to enroll in an HMO, you'll find the name of the HMO and your cost on the Citigroup Benefits Web Site or on your Personal Enrollment Worksheet. Review the HMO information sheets for details of coverage and HMO facts. HMO information sheets accompany your Personal Enrollment Worksheet and are available on the Citigroup Benefits Web Site.

For information about a specific HMO or a list of HMO providers, contact the HMO using the Web address or telephone number on the HMO information sheet.

OUT-OF-NETWORK BENEFITS

Some HMOs offer minimal out-of-network benefits. See the HMO information sheet for information on any out-of-network benefits offered.

The following HMOs will offer out-of-network benefits for [illegible]:
- C[illegible] Health Plans (CT, FL, NY);
- H[illegible] Blue Cross Blue Shield of New York; and
- In[illegible] Behavioral Health (NY).

CHOOSING A PCP

When you enroll in an HMO for the first time, you must select a primary care physician (PCP) for yourself and each family member you enroll. Otherwise, a network PCP will be assigned to you based on your home zip code. [illegible] HMOs, you'll receive an ID card showing the PCP's name. You must call your HMO to choose a PCP before you can use your HMO's services.

AETNA'S AEXCEL NETWORK

For participants in an Aetna HMO in CT, FL, GA, NJ, NY, and [illegible] Coast Area.

Aetna's Aexcel specialist program offers access to designated specialty care. To receive the highest level of benefits, HMO participants in the above locations must use Aexcel specialists in the following 12 specialties:
- Cardiology: heart and circulatory health;
- General surgery: [illegible] surgery, including coronary artery bypass and [illegible] procedures;
- Gastroenterology: diseases of the digestive system and [illegible] ulcerative colitis, intestinal irritation and inflammation, Crohn's disease, and colorectal cancer;
- General surgery: procedures such as appendectomies, hernia repairs, breast surgeries, and colorectal surgeries;
- Neurology: disorders of the nervous system such as [illegible] of the spine, movement disorders, multiple sclerosis, and seizures;
- Neurosurgery: surgery performed on the brain, spinal cord, and nerves;
- Obstetrics and gynecology: childbirth and women's health;
- Orthopedics: disorders of muscles, bones, and joints;
- Otolaryngology/ENT: ailments related to ears, nose, and throat;
- Plastic surgery: surgery to restore form and function to [illegible] diseased body parts;
- Urology: health of the male and female urinary tracts and the male reproductive organs; and
- Vascular surgery: surgery to correct problems in arteries and veins.

Aetna physicians in these specialty categories who rated highest overall in measures of clinical performance and cost efficiency were designated for inclusion in the Aexcel network. To locate an Aexcel specialist, visit the DocFind section of the Aetna Web site at **http://www.aetna.com**.

Review your benefit summary for details on the level of benefits provided.

DENTAL

Citigroup offers three dental options:
- Delta Dental;
- MetLife Preferred Dentist Program (PDP); and
- CIGNA Dental Care DHMO (dental health maintenance organization).

You can enroll in Citigroup dental coverage even if you don't enroll in Citigroup medical coverage. You can enroll in coverage for yourself or for yourself and your eligible dependents in one of the same four coverage categories available for medical coverage. See "Coverage categories" on page 12.

Both Delta Dental and MetLife PDP allow you to visit any dentist. However, when you visit a dentist in the Plan's network, you'll pay a discounted fee. See the Citigroup Benefits Web Site or your Personal Enrollment Worksheet for the cost of the options available to you.

Quick tip: Dental differences

CIGNA DHMO costs less from your pay than the other two options, but you must use a CIGNA Dental provider to receive a benefit, except in very limited circumstances. See "CIGNA Dental Care (DHMO)" on page 46.

[illegible] OPT[illegible] AT A GLANCE

	Delta Dental	MetLife Preferred Dentist Program (PDP)	CIGNA Dental Care (DHMO)[1]
An[illegible] deductible			
[illegible]	$50	$50	None
[illegible] maximum	$150	$150	None
[illegible] and d[illegible] services	100% paid, no deductible to meet[2]	100% paid, no deductible to meet[3]	100% paid when you use your network dentist
[illegible] Su[illegible] fillings, amalgam [illegible] anterior compos[illegible] [illegible] non molar), root c[illegible] periodontal services, [illegible] oral surgery	80% after deductible[2]	80% after deductible[3]	You pay a copayment when you use your network dentist
M[illegible] restorative services S[illegible] crowns, inlays/onlays, [illegible]	50% after deductible[2]	50% after deductible[3]	You pay a copayment when you use your network dentist
[illegible]	50% after deductible[2]	50% after deductible[3,4]	You pay a copayment when you use your network dentist
[illegible] orthodontia limit [illegible] and adults	$3,000 per person[4]	$3,000 per person[4]	Coverage limited to 24 months of treatment
T[illegible] temporo-mandibular j[illegible] treatment excluding [illegible]	50% after deductible	50% after deductible if not the result of an accident	Not covered
[illegible]	50% after deductible	50% after deductible, subject to "dental necessity"	Not covered
[illegible] maximum	$3,000 per person	$3,000 per person	None

[1] [illegible] schedule of [illegible] of providers by calling CIGNA Dental at 1-800-367-1037. If you're enrolled in CIGNA Dental, you also can obtain a sc[illegible] www.[illegible] You're entitled to see specialists as needed, with the approval of your network dentist.

[2] [illegible] providers [illegible] claims to Delta and to accept Delta's maximum plan allowances, or the dentist's actual charge, whichever is less [illegible] participating dentists are paid directly by Delta and, by agreement, can't bill you more than the applicable deductible or [illegible] participating dentist, you limit your out-of-pocket costs. For services performed by non-participating dentists, Delta sends [illegible] directly to [illegible] You're responsible for paying the non-participating dentist's total fee, which may include amounts such as deductibles and [illegible] of Delta's allowance and services that aren't covered by the group dental service contract.

[3] [illegible] accepted [illegible] for services. For services other than those for preventive care, you must meet the annual deductible before the plan w[illegible] amounts for out-of-network dentists are based on reasonable and customary charges for your geographic area.

[4] [illegible] 2007 under the MetLife and Delta Dental Plans will count toward the lifetime orthodontia maximum across both Plans.

C[illegible] plan for information [illegible] TMJ treatment it may cover.

[illegible] tip. The Health Care Spending Account can [illegible] money on your out-of-pocket health care [illegible]. You can contribute up to $8,000 in pre-[illegible] dollars to pay for your deductibles, copayments, [illegible], and other eligible medical, dental, [illegible] care expenses that aren't paid by any [illegible] you forfeit any money remaining in the [illegible] that you don't use, estimate conservatively.

D[illegible] DENTAL

D[illegible] offers:

- [illegible] to choose [illegible] dentist
- [illegible] network of dental providers in the United [illegible]
- [illegible] who accept agreed upon fees;
- [illegible] file when [illegible] at a network dentist;
- [illegible]-of-pocket [illegible] when using a network [illegible]
- [illegible] maximum [illegible] of $[illegible],000 per person

D[illegible] may be based on the least costly treat-m[illegible] conforms to generally accepted dental practice.

P[illegible]

P[illegible] services are covered at 100% of Delta's all[illegible] amount with no deductible. Oral cancer services ar[illegible] with no [illegible] up to a $3,000 life-ti[illegible]

P[illegible] services are:

- [illegible] exam: up to two exams per calendar year;
- [illegible] cleanings: up to [illegible] cleanings per calendar [illegible] combination of [illegible] or periodontal);
- [illegible] treatments: one application per calendar year, [illegible] 18;
- [illegible] to age 18;
- [illegible] full mouth [illegible] per [illegible] months and up to [illegible] bitewing X-rays [illegible];
- [illegible] up to age 16 [illegible] molars only); and
- [illegible] treatment [illegible] emergency treatment only

B[illegible]

Ba[illegible] are covered at [illegible] of Delta's allowed am[illegible] an annual deductible of $50 for an indi-vi[illegible] family) is [illegible]

Basic services are:

- Fillings: amalgam ("silver") and anterior composites ("white" non-molar); all other fillings will be considered for payment at the amalgam amount;
- Extractions;
- Endodontic treatment;
- Oral surgery;
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures; one relining or rebasing per 36 months;
- Periodontal treatment; and
- General anesthesia, when medically necessary.

Major services

Major services are covered at 50% of Delta's allowed amount after an annual deductible of $50 for an individual ($150 family) is met.

Major services are:

- Inlays, onlays, and crowns;
- Removable dentures: initial installation and any adjustments during the first six months; replacement of existing removable dentures or fixed bridgework with a new denture or the addition of teeth to a partial removable denture; to qualify for replacement, dentures must be at least five years old and unserviceable;
- Fixed bridgework: initial installation; replacement of existing removable dentures or fixed bridgework with new fixed bridgework or the addition of teeth to the existing fixed bridgework; to qualify for replacement, bridgework must be at least five years old and unserviceable;
- Dental implants: surgical placement of, prefabrication, superstructure, and replacement limited to once in a lifetime of the actual implant; and
- Temporomandibular joint (TMJ) disorder-related services: non-surgical services and/or supplies to prevent, diagnose, or correct an abnormal functioning of the temporomandibular joint of the jaw.

Orthodontia services

Orthodontia is covered for children and adults at 50% of Delta's allowance up to a lifetime maximum of $3,000 per covered person.

O[illegible] ntic services ar[illegible]

- [illegible] lontic X-rays an[illegible]
- [illegible] or supplies to prevent, diagnose, or correct a [illegible] ment of teeth or bite.

[illegible]

Th[illegible] ing services and supplies aren't covered:

- [illegible] ption drugs, premedications, relative analgesia;
- [illegible] s for hospitalization, including hospital visits.
- Plaq[illegible] control programs, including oral hygiene and [illegible] instruction.
- [illegible] ures to correct congenital or developmental [illegible] rmations except for children eligible at birth;
- [illegible] res, appliances or restorations primarily for [illegible] ic purposes,
- [illegible] g vertical dimension;
- [illegible] g tooth structure lost by attrition;
- [illegible] ntal splinting,
- [illegible] ical record [illegible];
- [illegible] ation; and
- Exp[illegible] mental procedures.

Delta Dental's networks

Delta Dental has two provider networks available to you through Citigroup: DeltaPremier and DeltaPreferred Option. Dentists in both networks agree to accept lower fees for services. The DeltaPremier network is larger with more than 152,000 dental offices nationwide. However, you'll receive a deeper discount in the smaller DeltaPreferred Option network with 78,000 offices nationwide.

Your total out-of-pocket payment is less if you use a DeltaPreferred Option network dentist, more if you use a DeltaPremier dentist. You'll pay more out of your pocket if you use a dentist who isn't in either Delta network. You can choose any dentist at the time of service, but you'll pay less out of your pocket when you use a network dentist.

For the names of participating providers:

- Visit the Delta Dental Web site at **http://www.deltadentalpa.org/citigroup**, or
- Call Delta Dental at 1-877-248-4764.

E[illegible]

[illegible] MING DEDUC[illegible] E HAS BEEN M[illegible]	DeltaPreferred Option participating dentist	DeltaPremier participating dentist	Out-of-network dentist
[illegible] charge for a [illegible]	$1,000	$1,000	$1,000
[illegible] allowance	$640	$800	$850
Plan [illegible] ys	$320	$400	$425
[illegible] ment amount (the [illegible] t you pay)	50% of $640 = $320	50% of $800 = $400	$575 (50% of $850 = $425 + $150, balance of bill)
[illegible]	$3[illegible]	$200	0
[illegible] amount [illegible]	$6[illegible]	$800	$1,000

No[illegible] numbers [illegible] for illustration only

Pr[illegible] of Benefits
Pre[illegible]mination of benefits enables you and your dentist to know in advance what the Plan will pay for any services Delta recommends that your dentist submit a claim before performing services that may total more than $[illegible].

Delta will review the claim and return the predetermination voucher to your dentist (with a copy to you) that explains eligibility, amount of benefits, and the definition of a [illegible]day period for completion of services.

When services are completed, the voucher with the dates of services and signatures should be submitted to Delta for payment. Delta will pay the predetermined amount depending upon your continued eligibility for coverage. The payment could be reduced if you're also eligible for coverage under another plan.

Dental necessary
When used in connection with non-emergency treatment, Delta Dental will determine dental necessity in terms of generally accepted dental standards. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply doesn't, in itself, make it a dental necessity.

When used in connection with emergency treatment, dental necessity means the treatment is necessary to relieve or prevent the immediate and substantial worsening of the condition.

File a claim
See "How to file a claim" on page 18.

METLIFE PREFERRED DENTIST PROGRAM (PDP)

MetLife PDP offers:
- The freedom of choice: you can visit any dentist at any time;
- A nationwide network of more than 79,000 dentists, including 18,500 specialists, who accept negotiated fees as payment in full;
- Current credentialing requirements for providers; and
- Participating providers' practices that you can view online or order by telephone and have faxed or mailed to you.

Preferred Dentist Program (PDP)
You can take advantage of the PDP feature, which consists of a network of dentists who accept fees that are typically 10% to 30% less than community average charges. When visiting a participating PDP dentist, you're responsible only for the difference between the Plan's benefit payment amount and the PDP fee.

To find out if your current dentist is in the PDP network:
- Visit the MetLife Web site at **http://www.metlife.com/dental**, or
- Call 1-888-832-2576 for a provider directory.

Preventive/diagnostic services
- Routine oral exams, maximum of two exams per calendar year;
- Routine cleanings, maximum of two cleanings per calendar year;
- Fluoride treatments (age 18 and under), maximum of one application per calendar year;
- Space maintainers (age 18 and under);
- Full mouth series and panoramic X-rays, once every 36 months;
- Bitewing X-rays, up to two bitewing X-rays per calendar year;
- Sealants, permanent molars only (age 17 and under), one application every 36 months; and
- Palliative treatments: emergency treatment only; not paid as a separate benefit from other services on the same day.

Basic services
- Fillings (except gold fillings): includes silver (amalgam), silicate, plastic, porcelain, and composite fillings to restore injured or decayed teeth; composite fillings for molars aren't covered;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Repair prosthetics: no limit;
- Recementing (crowns, inlays, onlays, bridgework or dentures): no limit;
- Denture relining and rebasing: once per 36 months;
- Periodontal maintenance treatments, up to four per calendar year, in combination with routine periodontal or prophylaxes cleanings;

- P[illegible]odontal scaling and root planning: no limit (subject to [illegible]tant review);
- B[illegible]ism appliance; and
- G[illegible] anesthesia, when medically necessary, as determ[illegible]d by the Plan administrator and administered in c[illegible]unction with a cov[illegible]ed service.

M[illegible]
- I[illegible]s, onlays, and c[illegible]owns (including precision attachm[illegible]es for dentures); limited to one per tooth every five ye[illegible]
- E[illegible]ovable dentures, initial installation, and any ad[illegible]stments made w[illegible]n the first six months;
- R[illegible]ovable dentures: replacement of an existing re[illegible]ovable denture or fixed bridgework with new den[illegible]th or addition of te[illegible]th to partial removable denture; d[illegible]ures must be at least five years old and unserviceable; limited to once every five years;
- F[illegible]d bridgework, including inlays, onlays, and crowns u[illegible]d to secure a bridge (initial installation);
- F[illegible] bridgework, including inlays, onlays, and crowns u[illegible]d to secure a bridge (replacement of an existing re[illegible]ovable denture or fixed bridgework with new f[illegible]dgework or addition of teeth to existing fixed b[illegible]dgework; bridgework must be at least five years old a[illegible] unserviceable); limited to once every five years;
a[illegible]
- P[illegible] implants (subject to medical necessity and con[illegible]t review); medical necessity, as determined by the P[illegible] Administrator, based on the number and distri[illegible]n of all missing (or replaced teeth in the arch, as w[illegible]l as the overall periodontal condition of the remaining [illegible]th.

O[illegible]
- C[illegible]
- F[illegible]
- T[illegible]n plan and bond;
- S[illegible] or supplies to prevent, diagnose, or correct a[illegible]gnment of teeth, bite, jaws, or jaw joint r[illegible]ship;
- R[illegible]able and/or fi[illegible] appliance(s) insertion for inter[illegible] or therapy;
- Temporomandibular joint (TMJ) disorder appliances (for TMJ dysfunction that doesn't result from an accident); and
- Harmful habit appliances; includes fixed or removable appliances.

Procedures and services that aren't covered

The following exclusions apply to MetLife PDP and aren't covered by the Plan:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Treatment performed for cosmetic purposes;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;
  - Teeth that are restorable by other means or for the purpose of periodontal splinting; and
  - Connecting (splinting) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes.
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Facings or veneers on molar crowns or molar false teeth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Charges incurred for services or supplies not recommended by a licensed dentist;

- C[illegible] sustained due to sickness or injury are covered by [illegible] Workers' Compensation Act or other similar legislation arising out of or in the course of any employment for occupation or labor for wage or profit;
- C[illegible] incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof for treatment of a service-connected disability;
- C[illegible] that, in the absence of this coverage, you would not be legally required to pay;
- C[illegible] resulting directly or indirectly from war (whether declared or undeclared);
- C[illegible] resulting from injury that's intentionally self-inflicted or from injury sustained while committing an assault or felony;
- C[illegible] for services or supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- C[illegible] for services or supplies that aren't generally accepted in the United States as being necessary and appropriate for the treatment of dental conditions or [illegible] experimental care;
- C[illegible] for nutritional supplements and vitamins;
- S[illegible] covered by auto or vehicle liability insurance;
- S[illegible] that would be provided free of charge but for coverage;
- B[illegible] appointments;
- C[illegible] for film, x-rays or charges for copies of X-rays;
- C[illegible] for services rendered to sound and natural teeth [illegible] to orthodontment;
- C[illegible] that exceed the access of the reasonable and customary charge;
- S[illegible], to any extent, are payable under any managed care products including HMO.

Pr[illegible] the alternate be[illegible]

Me[illegible] you obtain a predetermination of b[illegible] before having any procedure that will cost more than $500.

Bef[illegible] this is complete, the Plan will pay for covered pro[illegible] based on less-costly alternate treatment plans, satisfactory result based on generally recognized standards of care. You and your den[illegible] choose the more costly procedure, but you'll be responsible for the difference in cost between the benefit amount and the dentist's charge.

By requesting a predetermination of benefits, you'll know in advance how much you'll be responsible for paying. Then, you can choose whether to continue with the more expensive treatment or the alternate procedure. If you don't request a predetermination of benefits, you may find that the Plan will pay less than you anticipated or nothing at all, depending on the procedure and treatment provided.

Medical necessity

Medical necessity is the treatment of dental diseases such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Plan Administrator, acting through the Claims Administrator, reserves the right to determine whether, in its judgment, a service or supply is medically necessary or payable under this Plan. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply doesn't, in itself, make it medically necessary.

Filing a claim

See "How to file a claim" on page 18.

CIGNA DENTAL CARE (DHMO)

CIGNA Dental Care operates like a health maintenance organization: Once enrolled, you must receive all services from the CIGNA Dental Care provider you selected. Except for emergency treatment for pain, you won't be covered for any dental services you receive outside the CIGNA Dental network.

If you don't choose a primary dentist when you enroll, CIGNA Dental will assign a dentist to you based on your home zip code.

CIGNA confirms that each dentist in its network is properly licensed, certified, and insured and complies with government health standards.

Pla

- A [illegible]vide network of approximately 25,000 d[illegible]
- N[illegible]ibles to meet;
- N[illegible]or lifetime dollar maximums;
- N[illegible]charge for exams, x-rays, or routine cleanings;
- R[illegible]ces on covered procedures when there's a cl[illegible]
- Sp[illegible]d care with an approved referral at the same fe[illegible]participating dentist;
- A[illegible]ed Dental Office Locator for 24-hour in[illegible]tion by telephone or fax to help you find the ri[illegible]
- A[illegible]atic participation in the CIGNA Healthy R[illegible]SM program, which offers discounts on various h[illegible]ed services and products; for more informa-ti[illegible]http://www.cigna.com
- C[illegible]dontia for children and adults limited to 24 u[illegible]treatment; additional treatment is available at[illegible]ed cost of initial treatment;
- R[illegible]a pediatric dentist: Your network general d[illegible]arrange for one standing referral valid until th[illegible]seventh birthday for treatment by the same p[illegible]a dentist;
- C[illegible]g[illegible]general anesthesia and IV sedation *when m[illegible]lly necessary and performed by a network oral s[illegible]or periodontist for covered procedures*; general a[illegible]Dist[illegible]e nitrous oxide; and
- C[illegible]ed[illegible]ry six months at no charge f[illegible]ssibl[illegible]and gum[illegible]ou may pay for a[illegible]cleanings. Charges are listed on the Patient C[illegible]dule.

Lim[illegible]on[illegible]services

- Fr[illegible]See the Patient Charge Schedule for limitations or[illegible]ue of covered services, such as cleaning.
- Sp[illegible]ty[illegible]e: You must obtain pr[illegible]ent authorization fr[illegible]Delta Dental for coverage of services by a n[illegible]

- Pediatric dentistry: Coverage for referral to a pediatric dentist ends on a covered child's seventh birthday. CIGNA Dental may consider exceptions for medical reasons on an individual basis. The network general dentist will provide care after the child's seventh birthday.
- Oral surgery: The surgical removal of an impacted wisdom tooth isn't covered if the tooth isn't diseased or if the removal is for orthodontic reasons only.

Procedures and services that aren't covered

The services or expenses listed below aren't covered under the Plan. They're your responsibility at the dentist's usual fees.

- Services that aren't listed on the Patient Charge Schedule;
- Services provided by a non-network dentist without CIGNA Dental's prior approval (except emergencies);
- Services related to an injury or illness paid under Workers' Compensation, occupational disease, or similar laws;
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision, or a public program, other than Medicaid;
- Services relating to injuries that are intentionally self-inflicted (OH and TX residents: Services relating to injuries that are intentionally self-inflicted aren't excluded);
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- General anesthesia, sedation, and nitrous oxide unless specifically listed on your Patient Charge Schedule; when listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist (MD residents: General anesthesia is covered when medically necessary and authorized by your physician);
- Prescription drugs;

- P[illegible], appliances or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact); diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on the Patient Charges Schedule; or restore teeth that have been damaged by attrition, abrasion, erosion, and/or extraction (CA residents: The word "attrition" is excluded from this exception for medically necessary services or when functionality of teeth has been impaired);
- The initial installation of crowns and bridges, dentures, or root canal treatment that is in process on the effective date of your Dental Coverage (CA residents: Pre-existing conditions including the completion of crowns, bridges, dentures, or root canal treatment in process on the effective date of your coverage aren't excluded if otherwise covered under your Patient Charges Schedule);
- Replacement of lost and/or removable prosthodontic appliances or crowns that have been lost, stolen, or damaged due to recent abuse, misuse, or neglect;
- Services associated with the placement or prosthodontic restoration of dental implants;
- Services considered cosmetic, unnecessary or experimental in nature (CA and PA residents: This exclusion should read "services considered to be unnecessary"; PA residents: This exclusion should read "services considered experimental in nature");
- Professional charges for time spent both guidance or telephonic ("harmful habits");
- Hospitalization, including any associated incremental charges, unless the procedure is performed in a Hospital (Hospital Benefits are available for network dentist charges for covered services performed at a hospital; or hospital charges are covered and should be submitted to your medical plan for benefit determination);
- Services that are covered, or your dependent, is compensated for under any group medical plan, no-fault insurance policy or insured motorist policy; (Any exclusion for coverage for covered services to the extent compensated under group medical plan, no-fault insurance policies, or insured motorist policies are and dependents. Services compensated under no-fault auto insurance policies or insured motorists policies aren't excluded; MD residents: Services compensated under group medical plans aren't excluded);
- Crowns and bridges used solely for splinting; and
- Resin bonded retainers and associated pontics.

Except as set forth above, pre-existing conditions aren't excluded.

Visit the CIGNA Web site at **http://www.cigna.com**, or call 1-800-367-1037 for more information.

VISION CARE PLAN

The Vision Care Plan, administered by Davis Vision, offers a variety of routine vision care services and supplies. You don't have to be enrolled in the Plan to cover a dependent.

Both network and out-of-network benefits are available. You can split your benefit by going to both network and out-of-network providers. For example, you can obtain an annual eye examination from a Davis Vision provider while purchasing your frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

NETWORK BENEFITS

Network benefits include:

- Examination: one eye examination, including dilation, when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: one pair of eyeglasses each calendar year from the Davis Vision "Tower Collection" covered at 100%; or
- A $50 wholesale allowance toward the cost of any non-Tower frame or an equivalent retail allowance at a retail chain, for example, a $100 allowance at a Pearle Vision location; spectacle lenses will be covered at 100% with any non-Tower frame; or
- Contact lenses in lieu of eyeglasses: one pair or supply each calendar year in lieu of eyeglasses covered at 100%; lenses can be
  - Soft, standard daily-wear contact lenses; or
  - Plan-covered disposable/planned replacement lenses;

[illegible] lenses that aren't covered [illegible] Plan [illegible] ary, you'll receive a maximum [illegible] 105 [illegible] other lenses;
- [illegible] credit [illegible] toward non-plan contacts, [illegible]

- 2 [illegible] al pairs of glasses at a net- [illegible]

The following lenses are covered at 100%: glass or plastic lenses ([illegible] bifocal, trifocal); all prescription ranges, incl [illegible] lenses; tinting of plastic lenses; stan[illegible] premium progressive addition multifocals; poly[illegible] size lenses; ultraviolet coating; blen[illegible] (scratch-resistive) glass lenses; scra[illegible] intermediate-vision lenses.

Op[illegible] such as anti-reflective coatings, hi-i[illegible] lenses, and plastic photosensitive [illegible] a copayment.

OU[T-OF-NETWORK] BENEFITS

If y[illegible] outside the Davis Vision provider net[illegible] Plan [illegible] reimbursements of up to:
- Ann[illegible]
- L[illegible] bifocal, [illegible] trifocal, $45; le[illegible]
- F[illegible]
- C[illegible] ive; $225 medically necessary (v[illegible] Vision).

DE[FIN]ITION OF MEDICAL NECESSITY

Davi[illegible] your contact lenses to be me[illegible] appropriate in the treatment of [illegible] lenses may be medic[illegible] appropriate when their use, in lieu [illegible] tly better visual acu[illegible] function, including avo[illegible] suppression.

Con[illegible] determined to be medically necessary [illegible] keratoconus, anisometropia con[illegible] myopia, aniseikonia po[illegible] and irregular asti[illegible] and approve any cov[illegible] lenses.

LOW VISION

Low vision is defined as a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the usable vision that remains.

With prior approval by Davis Vision, covered low-vision services will include:

- Low-vision evaluation: One comprehensive exam is covered every five years with a maximum charge of $300; sometimes called a functional vision assessment, this exam can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast, and lighting requirements for optimum vision.
- Maximum low-vision aid: Aids such as high-power spectacles, magnifiers, and telescopes are covered at a maximum of $600 per aid with a lifetime maximum of $1,200. These devices are used to improve the levels of sight, reduce problems of glare, or increase contrast perception based on the individual's visual goals.
- Follow-up care: The Plan covers four visits in any five-year period with a maximum charge of $100 per visit.

LASER VISION CORRECTION

Laser vision correction isn't a covered benefit under the Citigroup Plan. However, a discount is available if you use a provider in the Davis Vision laser vision correction network. You're eligible for up to a 25% discount off the provider's reasonable and customary fees or a 5% discount off any advertised fee for laser vision correction surgery at a Davis Vision provider.

Some facilities may offer a flat rate, which equates to these discount levels. You're responsible to pay all fees directly to the provider or facility. Davis Vision and Citigroup assume no financial responsibility for access to these discounts in your location.

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call Davis Vision at 1-877-923-2847 or visit http://www.davisvision.com. Enter Citigroup code 2227 for a list of participating providers.

[illegible]

D[illegible]

Sho[illegible] and Long Term Disability (LTD) benefits are available to replace a portion or all of your ear[illegible] work due to an illness, injury, or pregnancy.

ST[illegible]

The [illegible] continuation) is a core benefit available to all benefits-eligible employees. No enrollment is necessar[illegible] must report all disabilities to the Plan administrator before you can receive a benefit.

STI[illegible] base salary (not total compensation) during an approved disability of up to 13 weeks based on [illegible]

S[illegible]ts			
Ye[illegible]vice	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of base salary
[illegible] month	0	0	0
1[illegible] year	1	12	13
1[illegible]	4	9	13
2[illegible]	6	7	13
3[illegible]	8	5	13
4 years [illegible] less than [illegible]	10	3	13
5[illegible]	13	0	13

For [illegible] consultant associates, investment associates in Global Wealth Management and acc[illegible] Corporate and Investment Bank, the following schedule of benefits applies:

Y[illegible]	Minimum benefit (% of total compensation)	Plus additional benefit	Maximum benefit (% of total compensation)
1[illegible] years	[illegible]%	Commissions	100%
3[illegible]	70%	Commissions	100%
7[illegible]	80%	Commissions	100%

For [illegible] **commission working in the Glo**[illegible]: You'll receive STD benefits bas[illegible] (and not based on total com[illegible]). If [illegible] missions are generated while you [illegible] STD [illegible] they'll be paid in addition to the STD [illegible] based [illegible] length of service.

If y[illegible] **business analyst paid a mo**[illegible] [illegible] receive STD benefits based on [illegible] commissions.

For [illegible] **on commission:** Ask your HR [illegible].

W[illegible] STD [illegible] incur a total disability whi[illegible] total disability" is defined as a [illegible], pregnancy, or injury that resu[illegible] perform the essential duties of y[illegible] for more than seven consecutive [illegible] remain totally disabled and are [illegible] eighth calendar day, STD ben[illegible] will begin on the eighth day of [illegible] retroactive to the first day of [illegible].

Yo[illegible] a disability if your illness, inj[illegible] prevents you from commuting to [illegible] STD benefits, you must be [illegible] treatment on a continu[illegible] health care provider. You can[illegible] if you return to work on a part[illegible] work in California.

If y[illegible], return to work, and then wi[illegible] you're unable to return to work for the same or a related total disability, your absence will be processed as a recurrent claim and you'll be eligible to receive the *balance* of your STD benefits (for a reduced period to reflect the STD benefits paid during your absence).

For employees in California

If you're eligible for disability benefits and work in California, you're covered by the Citigroup California Voluntary Disability (VDI) Plan, unless you reject the plan. The VDI Plan replaces the state plan.

If you're covered by the VDI plan, you don't need to file a claim with the state. You report your disability to MetLife.

LTD

LTD coverage is offered to continue 60% of your total compensation when an approved disability continues for more than 13 weeks.

Citigroup provides company-paid LTD coverage to employees whose total compensation is less than or equal to $50,000.99, while employees with total compensation of $[illegible]001 and above can buy coverage. The cost of LTD coverage is shown on the Citigroup Benefits Web Site or on your Personal Enrollment Worksheet.

If you've been enrolled in the Plan for one year and leave Citigroup, you can convert your Citigroup LTD coverage under the group policy to an individual policy. The maximum benefit of this individual policy is $3,000 per month.

If [illegible] is:	
$[illegible]	• Citigroup provides LTD coverage at no cost to you. • Your benefit is tax[illegible].
[illegible] 001 [illegible] 00	• You'll pay for cove[illegible]e with after-tax dollars. • Your benefit isn't taxable.

[illegible] $50,000.99 during the year and you want LTD coverage for the follow[illegible] year, you must enroll during annual enrollment. [illegible] coverage as of the first of the following year.

If you [illegible] to [illegible] ...ase coverage, you'll be required to provide evidence of good health before coverage will be approved.

You may [illegible] ...e LTD benefits after 13 weeks of an approved STD. Benefits are paid monthly and continue for a [illegible] ...s your disability continues, up to age 65 (or longer, depending on your age when your disability begins). [illegible] ...mediately below.

AGE DISCRIMINATION IN EMPLOYMENT ACT (ADEA) SCHEDULE	
[illegible] ...s begins	**Date monthly LTD benefits will stop**
Age 60 and [illegible]	The later of: • Your 65th birthday [illegible] • The date the 42nd monthly benefit is payable
Age 61	The date the 36th monthly benefit is payable
Age 62	The date the 30th monthly benefit is payable
Age 63	The date the 24th monthly benefit is payable
Age 64	The date the 21st monthly benefit is payable
Age 65	The date the 18th monthly benefit is payable
Age 66	The date the 15th monthly benefit is payable
Age 67 and over	The date the 12th monthly benefit is payable

Unl[illegible] e financi[illegible] dependent, you should think of [illegible] ection a[illegible] ntial element of your per-son[illegible] al plan [illegible] TD coverage protects you in the [illegible] ur ability to work is impaired by an accident or ill[illegible]

You [illegible] ve to en[illegible] Citigroup LTD coverage. How[illegible] you dec[illegible] enroll in LTD coverage at any time [illegible] han when [illegible] ligible or as the result of a qua[illegible] [illegible] ou must take a physical exam and [illegible] de evide[illegible] good health. In addition, the Plan w[illegible] ever any [illegible] ility caused by, contributed to, or [illegible] to [illegible] ing condition until you've bee[illegible] d in the [illegible] 12 consecutive months.

A p[illegible] ng condit[illegible] injury, sickness, or preg-nan[illegible] hich — in [illegible] three months before the effec-tive [illegible] coverage [illegible] received medical treatment, con[illegible] care o[illegible], took prescription medica-tion [illegible] me [illegible] escribed; or had symptoms that [illegible] ause [illegible] ly prudent person to seek diag[illegible]

W[illegible] able

For [illegible] LTD benefits, a disability m[illegible] pregnancy, or accidental inj[illegible] propriate care and treatment fr[illegible] on a continuing basis and are [illegible] own occupation for any em[illegible] your [illegible] oday.

LT[illegible] after you're approved for and [illegible] 13 [illegible] tinuous STD benefits. To qu[illegible] TD [illegible] must be under the con-tin[illegible] physician during the STD pe[illegible]

If [illegible] return to work, and then, w[illegible] day [illegible], you're unable to work as [illegible] lated total disability, your ab[illegible] recurrent claim and you'll be [illegible] receive [illegible] ce of your STD benefits. LT[illegible] you're approved.

Th[illegible] benefits is subject to the [illegible] applicable Plan. This se[illegible] substitute for the actual Pl[illegible]

To review the STD [illegible] LTD Plan documents, visit **http://www.benef[illegible]okonline.com**.

LIFE INS[illegible]ANCE BENEFITS

BASIC LIFE/[illegible]D&D INSURANCE

Citigroup provides [illegible] sic Life insurance (through MetLife) and Accidental Deat[illegible] nd Dismemberment (AD&D) insurance (throug[illegible] IGNA) at no cost to you. AD&D pays a benefit if y[illegible] dismembered or die as a result of an accidental inju[illegible]

The benefit is equ[illegible] total compensation to a maximum of $20[illegible] rounded up to the nearest $1,000. This amou[illegible] won't change during the year if your total comp[illegible] changes. Total compensation is recalculated each [illegible], and the new amount is effective each January 1.

Since Citigroup pays [illegible] he full cost of your Basic Life insurance, you must [illegible] taxes on the value of the cover-age above $50,0[illegible] required by the IRS, this amount, called "imputed in[illegible]," will be added to your taxable pay and shown on [illegible] r pay statement and Form W-2 Wage and Tax St[illegible] the year in which coverage was effective. Im[illegible] is based on the amount of Basic Life insur[illegible] coverage above $50,000 and your age.

If your total com[illegible] tion is more than $50,000, you may elect only $[illegible] Basic Life insurance. You won't be subject to [illegible] imputed income, but you'll also forego the addition[illegible] nefit. You won't have the oppor-tunity to enroll [illegible] equal to your total compen-sation until the [illegible] enrollment period.

Basic Life Acc[illegible] nefits Option

The accelerated [illegible] (ABO) of your life insur-ance coverage is a[illegible] le if you become terminally ill due to injury or s[illegible] ss and are expected to die within six months.

Under the ABO, [illegible] ive up to 50% of your Basic Life amou[illegible] to [illegible] $100,000, less any applicable expense [illegible]. The minimum amount that will be paid [illegible] of 25% of your Basic Life amount or $7,5[illegible] celerated benefit will be paid in a lump sum un[illegible] you or your legal representative selects another [illegible] le.

To [illegible] fit, MetLife will require the following proof [illegible] nal illness:

- A [illegible] nefit claim form, available from [illegible];
- A [illegible] ation that states you're terminally [illegible];
- A [illegible] ation by [illegible] an of MetLife's choice, if requested [illegible] to you.

A [illegible] id only once in your lifetime. [illegible] asic Life benefit paid to your [illegible] reased by the amount of the accelerated benefit [illegible] any interest and expense charge.

OPTIONAL GUL SUPPLEMENTAL AD&D [illegible]

The [illegible] emental AD&D coverage described [illegible] ee benefit arrangement sponsored by Citigroup [illegible] urance coverage is offered [illegible] to employees of Citigroup and [illegible] diary.

[illegible]

You [illegible] .L insurance for yourself from [illegible] 10 times [illegible] al compensation up to a maximum [illegible] of $5 million. If your total compensation [illegible] ultiple of $1,000, your coverage [illegible] ded up to the next $1,000.

If [illegible] our initial eligibility period (31 [illegible] or for an amount greater [illegible] compensation or $1.5 m[illegible] ence of good health before coverage [illegible] ount of coverage, will be effective.

Y[illegible] unt of coverage you elect, you [illegible] used tobacco products in [illegible]

If [illegible] educed, your Optional GUL [illegible] be based on the higher [illegible] il the Benefits Service Center [illegible] al GUL amount be [illegible] age, you can increase [illegible] multiples of your total compensation [illegible] ed to provide satisfactory evidence of good health before the increased coverage will become effective.

If you leave Citigroup, you can continue coverage. MetLife will bill you directly at a higher rate than the Citigroup group rate. The rate will become effective in the month following your termination of employment.

Once enrolled for Optional GUL (provided by MetLife), you automatically receive supplemental AD&D coverage in the same amount as your GUL coverage. AD&D coverage is provided by CIGNA.

Optional GUL Accelerated Benefits Option

The accelerated benefits option (ABO) of your GUL coverage is available if you become terminally ill due to injury or sickness and are expected to die within six months.

Under the ABO, you can receive up to 50% of your GUL insurance amount, not to exceed $250,000, less any applicable expense charges. The accelerated benefit will be paid in a lump sum unless you or your legal representative selects another payment mode.

To receive an accelerated benefit, MetLife will require the following proof of terminal illness:

- A completed accelerated benefit claim form available from MetLife;
- A signed physician certification that states you're terminally ill; and
- An examination by a physician of MetLife's choice, if requested, at no cost to you.

Accelerated benefits can be paid only once in your lifetime. Upon your death, the GUL benefit paid to your beneficiary will be reduced by the amount of the accelerated benefit paid plus any interest and expense charge.

Accelerated benefits are not payable if:

- You've assigned your death benefit;
- All or a portion of your death benefit is to be paid to your former spouse as part of a divorce agreement;
- You attempt suicide or injure yourself on purpose;
- The amount of your death benefit is less than $15,000; or
- You're required by a government agency to request payment of the accelerated benefit so you can apply for, obtain or keep a government benefit or entitlement.

[illegible] (CAF)
W[illegible] GUL/Supplemental AD&D co[illegible] in the CAF. The CAF allows yo[illegible] a competitive rate of inter- est [illegible] contributions are deducted fr[illegible]. The minimum contribu- ti[illegible] year.

Th[illegible] maximum you can co[illegible] GUL coverage am[illegible] factors. You'll see your mi[illegible] contributions on the Citigroup B[illegible] Personal Enrollment Work- sh[illegible] amount of your contribution a[illegible] in coverage amounts could a[illegible]. For details, call MetLife at 1-[illegible]

Y[illegible] while it remains in t[illegible] only when you withdraw m[illegible] up to that point for C[illegible] premiums) plus your C[illegible]

F[illegible] CAF, call MetLife at 1[illegible]

C[illegible] partner
Y[illegible] GUL insurance coverage for y[illegible] in increments of $10,000 t[illegible] don't need to buy C[illegible] AD&D for yourself to elect co[illegible] domestic partner.

W[illegible] eligibility, you can enroll fo[illegible] domestic partner coverage w[illegible] partner providing evi- d[illegible] health.

If [illegible], your spouse/domestic p[illegible] good health for any a[illegible] partner coverage.

T[illegible] of coverage you elect, y[illegible], and whether he/she h[illegible] the past 12 months.

If [illegible] spouse/domestic partner can c[illegible] bill him or her directly at a [illegible] group rate. The rate will become effective [illegible] month following your termina- tion of employm[illegible]

You also can op[illegible] Accumulation Fund in your spouse's/domestic [illegible] name.

Once enrolled [illegible] GUL (provided by MetLife), your spouse/dom[illegible] partner automatically will receive Supplemental AD[illegible] coverage in the same amount as his/her GUL cove[illegible] AD&D is provided by CIGNA.

Coverage for [illegible] children
If you've enrolled [illegible] optional GUL/Supplemental AD&D coverage for you[illegible] your spouse/domestic partner, you can enroll f[illegible] AD&D insurance from $5,000 to $20,000, in $5,[illegible] dependents, for your eligible depen- dent children. *A [illegible] must be at least 15 days old to be covered.*

When you enroll [illegible] life coverage for your child, all of your eligible c[illegible] are covered automatically.

Once enrolled fo[illegible] (provided by MetLife), your child automatica[illegible] Supplemental AD&D cover- age in the same a[illegible] the child life coverage. AD&D is provided by C[illegible]

Note: If you're e[illegible] child coverage and have or adopt another c[illegible] must report your child's birth or adoption to t[illegible] Service Center so the new child can be cov[illegible]

BUSINESS T[illegible] L ACCIDENT INSURANCE

Business Travel A[illegible] (BTA) provides accident insur- ance only and p[illegible] for bodily injury and/or death; it *doesn't* [illegible] coverage for sickness. Coverage is provided by C[illegible]

All regular full-t[illegible] part-time employees have BTA coverage of five [illegible] compensation to a maximum benefit of $2 mi[illegible] spouse/domestic partner and/ or dependent chi[illegible] considered covered persons and have BTA c[illegible] while accompanying you on a business or rel[illegible] paid for by the Company.

- An eligible sp[illegible] domestic partner has a coverage amount of $1[illegible]

- ... child has a coverage amount

B... paid ... of death, dismember-
m... speech and/or hearing while
... made on behalf of the
C... are subject to
li...

Y... person or persons designated
... at your death, is the same
be... rance.

L... (LTC) INSURANCE

Y... for yourself and eligible
m... time.

T... family members must reside
in... and the District of Colum-
b... may apply even if you
d... family m... are:

- ... artner';
- ... -in-law,
- ... adult children of your
- ...

E... older.

If ... during your initial benefits ... provide evidence of good h...

If ... You must provide evi-
d... to John Hancock.

In... effective the first of the
m... approved, as long as
y... date. If you aren't at work
o... otherwise have become
el... come effective the first of
th... to work as an active
e...

P... spouse/domestic partner will
b... you'll pay for coverage with
a... on your age when you
b...

Y... complete an application form

and must provide ... of good health acceptable to John Hancock be... coverage will be approved. Coverage will be effec... first of the month after their application is app... provided they're not disabled on that date.

Family members, ... an spouses/domestic partners, will be billed dir... they're disabled on that date, coverage will tak... the first of the month after their disability ends, p... they're still eligible.

For information o... st of LTC coverage for yourself or other eligible f... mbers, you can request an enrollment kit or ... personal rate quote by visiting the John Hancock ... e at **http://groupltc.jhancock.com**. The user na... oupltc," and the password is "mybenefit." You ... n call John Hancock at 1-800-222-6814.

Family members ... the Web site or call to obtain information shou... e your name as the Citigroup employee.

Enrolling in LT... age

Enrolling in LT... ge will be different from enrolling in o... oup health and welfare benefits. You'll en... coverage directly with John Hancock by subm... an enrollment form to John Hancock or clickin... a link from the Citigroup Benefits Web Si... le family members must complete an en... form.

When LTC ben... payable

In general, LTC b... come payable if a licensed health care prac... ifies that:

- You require s... assistance from another person to perform at l... activities of daily living" due to a loss of func... ity that's expected to continue for at least 90 days.
- You need substanti... pervision due to a "cognitive impairment."

Activities of dail... nerally include bathing, maintaining con... ressing, toileting, eating, and transferring ... of a bed or chair. Cognitive impairment ... ration or loss of intellectual

... residing in LA and VA or to same-sex domestic partners residing ...

[illegible] ...eimer's disease and similar [illegible]

[illegible] ...fits only upon confirmation [illegible] by a care coordinator from [illegible]

[illegible] ...benefits generally won't be [illegible] -day "qualification period" [illegible] ...n Hancock certifies that you [illegible] ...quirements. The qualifica- [illegible] ...only once as long as you [illegible]

[illegible] ...ust continue through this [illegible] ...actually incur expenses, [illegible] ...be hospitalized during [illegible] payable for covered charges [illegible] ...ion period is met as long as [illegible]

Benefits [illegible] ...overed

LTC benefits will co... ...ual charges incurred for qualifying service... ...generally include nursing home care, alter... ...facility, community-based pro- fessional care, inf... ...re, and stay-at-home benefits. Depending on th... ...service, benefits are subject to a maximum, wh... ...ary based on the coverage level you choose.

Choosing a le... ...erage

From the six opt... ...e table below, you must choose a daily maximum... (DMB) from $100 to $350 a day in $50 incremen... ...e DMB is the most the Plan may pay for all cov... ...rvices received on any day. Each DMB has a ... ...ding lifetime maximum ben- efit (LMB), which... ...tal amount payable for covered LTC services wh... ...nsured. Informal care is also subject to a cale... ...maximum.

	Option 1	Option 2	Option 3	Op...	Option 5	Option 6
[illegible]	...100	$150	$200	$2...	$300	$350
[illegible]	...100	$150	$200	$2...	$300	$350
[illegible]	...75	$112.50	$150	$1...	$225	$262.50
[illegible]	$25	$37.50	$50	$62	$75	$87.50
[illegible]	...50	$1,125	$1,500	$1...	$2,250	$2,625
[illegible]	...82,500	$273,750	$365,000	$4...	$547,500	$638,750
[illegible]	...,000	$4,500	$6,000	$7,...0	$9,000	$10,500

[illegible] ...tly. Call John Hancock at 1-800-222-6814 for details.

[illegible] ...such as adult day health care and the following services pro... [illegible] ...home health care, hospice care, and [illegible] ...ed or employed through a licensed home health care agency.

[illegible] ...received in any calendar year is 30 times the informal care DA...

The contingent non-forfeiture benefit can be exercised only in the event of a substantial premium increase. The contingent non-forfeiture benefit allows you to stop paying premiums and keep a reduced level of coverage.

If you exercise this benefit, you'll keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of the total amount of premiums paid for your insurance since your coverage was issued or 30 times the DMB. A substantial premium increase would range from 10% at issue-age 90 or older to 200% at issue-age 29 or younger as detailed in the certificate that you'll receive if you're approved for coverage.

Choosing inflation protection: ABI or future purchase option

You also have the choice of including the automatic benefit increase (ABI) inflation protection provision at enrollment for an additional cost. If you don't elect this option, the future purchase option provision will be included in your coverage.

Under the ABI option, increases to your benefit amounts occur automatically each year. Every January 1, beginning January 1, 2006, the DMB amount will be increased at an annual rate of 5% compounded. The LMB will be increased in proportion to the increase in the nursing home DMB. If your insurance becomes effective January 1, no increase will apply on your effective date of coverage.

The benefit increase will continue to be made annually regardless of your age or whether you've met the benefit eligibility requirements under the policy. However, no future increases in benefit amount will apply if you stop paying premiums and continue coverage in effect on a reduced paid-up basis under the non-forfeiture benefit.

Under the future purchase option, you'll be offered additional amounts of coverage every three years to keep up with inflation. The amount of each adjustment will reflect an increase to the DMB of at least 5% compounded annually for the applicable period.

The premium rates for the inflation increase will be based on your attained age on the effective date of the increase and will include an additional charge to account for the added risk associated with accepting these offers.

The LMB increase in proportion to the increase in inflation adjustment won't be age 64 or older or if you've reduced benefit amounts under the policy increase effective date or if paid-up status. (If you're a s, this provision varies at 1-800-222-6814 for

Visit at http://grouplte.jhan- "groupltc," and the pass- tool that can help you provision may suit

A benefit is included in your your estate a portion benefits paid or pay- while covered under premium is based on your below. Premiums aren't or if coverage is in

Percentage of premium
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Waiver of premium

Once you complete the qualification period, and provided you meet the benefit eligibility requirements under the policy on that date, your premium payments will be waived. The waiver will continue as long as you remain eligible for benefits.

Portability

If you retire or leave Citigroup, you may continue coverage at group rates. You'll pay premiums directly to John Hancock.

Bed reservation benefit

The Plan will continue to pay nursing home or alternate-care facility benefits for up to 60 days per calendar year if you leave the facility on a short-term basis while receiving Plan benefits.

Alternate plan of care

An alternate plan of care can be established by mutual agreement among you, a licensed health care practitioner, and John Hancock if the John Hancock care coordinator identifies alternatives to the current plan that are both appropriate for you and cost-effective. The alternate plan of care may provide benefits for services or supplies not otherwise covered by the Plan. Any benefits paid under an alternate plan of care will reduce the LMB.

Restoration of benefits

The restoration of benefits feature allows you to restore your LMB if you provide proof that you:

- Haven't met the benefit eligibility criteria during the 24-month period up to and immediately preceding the date you request to restore your LMB;
- Haven't exhausted your LMB; and
- Have been continuously insured on a premium-paying basis for at least 24 months just prior to your request.

Restoration doesn't apply if coverage is in reduced paid-up status. Your stay-at-home benefit lifetime maximum won't be restored.

[illegible] exclusions

[illegible] the Plan contains a [illegible] that may reduce or [illegible] payable under the Plan [illegible] another plan. (This provision of CT.)

[illegible] benefits for charges incurred by [illegible] circumstances, such as intentional [illegible] that are reimbursable or [illegible] Medicare except for [illegible] deductible provisions under [illegible] specifically provided for [illegible] alcohol or drug [illegible]

[illegible] in all states and may [illegible] in which you live. The Certificate [illegible] once you're approved [illegible] exclusions for your state. If [illegible] guidelines where the [illegible] actually delivered to you [illegible]

[illegible] specifications specified in [illegible] services and supplies [illegible] such a plan of care [illegible] the practitioner.

[illegible] Plan is funded through a [illegible] a qualified LTC insurance [illegible] 7702B of the IRC.

[illegible] that vary depending [illegible] exclude your premium [illegible] on your federal income [illegible] expenses, including the [illegible] exceed 7.5% of [illegible] deductible dollar limits are [illegible] by the Secretary and adjusted [illegible] under the policy [illegible] income. Consult your [illegible] for more details.

For more information

To obtain details of the coverage available and its cost, contact John Hancock either by:

- Calling the John Hancock Long-Term Care Insurance Department at 1-800-222-6814, or
- Visiting the John Hancock Web site at **http://groupltc.jhancock.com**. The user name is "groupltc," and the password is "mybenefit."

Your family members who call or visit the Web site should provide your name as the Citigroup employee.

SPENDING ACCOUNTS

Spending accounts allow you to pay for certain health care, dependent care, and transportation expenses with pretax contributions from your pay.

- Health Care Spending Account (HCSA): Use the HCSA to pay for certain health care expenses for yourself and your qualified dependents that aren't paid by any medical, dental, or vision plan.
- Dependent Care Spending Account (DCSA): Use the DCSA to pay for certain dependent day care expenses so that you (and your spouse, if you're married) can work or look for work (this account isn't used to pay health care expenses for your dependents).
- Transportation Reimbursement Incentive Program (TRIP): Use the TRIP to pay for the cost of public transportation and parking so you can commute to work. **Note:** TRIP isn't part of annual enrollment. You can enroll at any time; coverage will begin the first of the following month.

Once enrolled, you can obtain information about your own account online by:

- Visiting the Citigroup FlexDirect Spending Account Web site through Total Comp at Citigroup at **https://www.totalcomponline.com** or
- Going directly to **http://www.flexdirect.adp.com/citigroup**.

F[illegible] REC[illegible] T CARD

V[illegible] [illegible]ge[illegible]nding accounts — [illegible]Sa[illegible]sit Account, or TRIP Park- in[illegible] [illegible] [illegible]natically receive a Citigroup F[illegible] Direct debit card[illegible] at[illegible] provider that accepts M[illegible]terCard[illegible] [illegible] [illegible]ne[illegible].

Yo[illegible] [illegible]ns[illegible]ed to your account as f[illegible]

If[illegible] [illegible]nual enrollment period:

- [illegible] of your 2006 contributions [illegible] January 1.
- [illegible] [illegible]ed to your card as [illegible]p
- [illegible] Transit Account): Contribu- [illegible] as they're deducted [illegible]p

If[illegible] [illegible] enroll as follows:

- [illegible] of your 2006 contributions [illegible] within 31 days after you [illegible]
- [illegible] [illegible]ed to your card as [illegible]p
- [illegible] Transit Account): Contribu- [illegible] as they're deducted

S[illegible]

F[illegible] debit card be sure to save yo[illegible] [illegible]quired at a later date to s[illegible] [illegible] eligible under the P[illegible] [illegible] may be considered [illegible]

DCAA warning

In accordance with IRS guidelines, the FlexDirect card shouldn't be used to pay for *future* qualified expenses.

Using the debit card for Transit Account expenses

Use the FlexDirect debit card to purchase monthly passes, fare cards, tickets, or vouchers. You may still file paper claims for eligible expenses. You may spend or be reimbursed up to the amount in your Transit Account at the time of purchase, subject to the IRS monthly pretax limit and, if applicable, the amount of your after-tax contribution.

If you commute within any of the following areas, you may be required to use the debit card for your transit expenses and can't submit paper claims: Denver, CO; Hartford, CT; Washington, DC; Chicago, IL; Boston, MA; Detroit, MI; Minneapolis, MN; Charlotte, NC; Portland, OR; Philadelphia and Pittsburgh, PA; and Dallas, TX.

Using the debit card for Parking Account expenses

Use the FlexDirect debit card to pay for monthly parking permits, garage fees, etc. You may still file paper claims for expenses such as parking meters or garages where MasterCard isn't accepted. You may spend or be reimbursed up to the amount in your Parking Account at the time of purchase, subject to the monthly IRS pretax limit and, if applicable, the amount of your after-tax contribution.

[illegible] ACCOUNTS AT A GLANCE

	Health Care Spending Account (HCSA)	Dependent Care Spending Account (DCSA)	Transportation Reimbursement Incentive Program (TRIP)[1]
Why enroll?	To reduce your taxes by paying for qualified expenses with pretax dollars		
[illegible] these?	IRS-qualified health care expenses for you and your family that aren't paid by any medical, dental, or vision plan.	IRS-qualified dependent day care expenses for your qualified dependents so that you (and your spouse, if you're married) can work or look for work.	Eligible transit and parking expenses.
How much do you contribute?	From $120 to $8,000 per year; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period; total contributions per family can't exceed $5,000 per year.	**Transit:** From $10 to $105[2] per month pretax; up to $300 in after-tax dollars. **Parking:** From $10 to $200[2] per month pretax; up to $210 in after-tax dollars.
[illegible] process	You'll forfeit any money you contribute each calendar year that you don't use by March 31 of the following calendar year.[3]	You'll forfeit any money you contribute each calendar year but you don't use.	If your account remains inactive for 12 consecutive months, you'll forfeit any remaining contributions.
Changes [illegible] year?	You can change your election as the result of a qualified status change; you can't enroll in December for the current year.[4]	You can change your election as the result of a qualified status change; you can't enroll in December for the current year.	You can enroll or change your election at any time; enrollment/changes are effective the first of the following month.
[illegible] claim	You must file claims for 2006 expenses so they're postmarked no later than June 30, 2007.	You must file claims for 2006 expenses so they're postmarked no later than June 30, 2007.	You must file claims for expenses within 12 months of the date on which the expense was incurred.

[illegible] Effective at any time, and your enrollment will be effective the first of the following month.
[illegible] IRS could increase the limits for 2006 in late fall 2005.
[illegible] at year-end of 2005 can be carried over into a portion of the following year. For example, you can use your 2005 [illegible] incurred through March 15, 2006. You must file claims to be paid with 2005 contributions by June 30, 2006.

H[illegible] [illegible] [illegible]
A[illegible] [illegible]

Yo[illegible] [illegible] pro[illegible] [illegible] he[illegible] [illegible] pe[illegible] [illegible] to[illegible]

Yo[illegible] [illegible] in[illegible] [illegible] co[illegible] [illegible] 3[illegible] [illegible]

[illegible] $1[illegible] and $8,000 a year on a [illegible] for eligible out-of-pocket [illegible] are taken each pay [illegible] ections, state and local

[illegible] s incurred only dur- [illegible] n enroll as a new [illegible] ment period, or within [illegible] atus. However, you can't [illegible] alendar year.

You may change or stop your contributions as a result of a qualified change in status.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines, the Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants to ensure that the HCSA isn't deemed to discriminate in favor of highly compensated employees.

HCSA CARE S	G COUNT RULES AND FEATURES
G M	penses that the Internal Revenue Service (IRS) considers as deductible on your
rule out	are eligible for reimbursement from a HCSA, provided the expenses aren't reimbursed
e s	ce.
Y	sed for your expenses or those incurred by anyone you can claim as a dependent on
y	rdless of whether you or your dependent is covered under any Citigroup medical,
d	n.
	onservatively. You can't receive a refund for contributions intended to reimburse
	y or procedure that's later canceled.
E s	• of enses that aren't paid by your medical, dental, and/or vision plan, such as deduct-
e	and copayments;
	• exceed what your medical, dental, and/or vision plan will pay, such as charges
	and customary amounts or other plan limits;
	• uch as exams, prescription eyeglasses and sunglasses, contact lenses, and laser
	covered by your medical or vision plan;
	• ses, such as exams, hearing aids, and hearing aid batteries, that aren't covered by
	• and training for disabled individuals;
	• , such as Lamaze, for up to two people;
	• hat isn't covered by your medical plan;
	• psychiatric therapy, and counseling that aren't covered by your medical plan;
	• accines, and immunizations that aren't covered by your medical plan;
	• ceptives and infertility treatments that aren't covered by your medical plan;
	• programs;
	• nter drugs for which you have a receipt;
	• d by a doctor that your medical plan or prescription drug program doesn't cover;
	• essary to obtain certain health care services.
	• you've been reimbursed from another source, such as Citigroup's or another
	dental, and/or vision plan, Medicare, or Medicaid;
	• gery or cosmetic dental work;
	• e taken for general health purposes, including those recommended by your doctor;
	• diaper services;
	• care for a healthy newborn;
	• custodial care at home or in an institution, even if recommended by your doctor;
	• ercise classes, or weight-loss programs for general health purposes, even if recom-
	ctor;
	• s, or toothpaste;
	• or medical and dental insurance premiums; and
	• ices.
	about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at
	or contact your tax adviser. You also can call the IRS at 1-800-829-1040.
	tion is a guideline for use in preparing tax returns; it isn't a description of the

[illegible] you to be reim-
[illegible] without having to
[illegible].

[illegible] will be submitted
[illegible] incurred under the
[illegible]:

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible] shield, CIGNA, and
  [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible] have eligi-
[illegible], the amount of
[illegible] to your HCSA.
[illegible] card to pay for an
[illegible] balance automatically
[illegible] ose expenses, and
[illegible] out

[illegible] ion is available
[illegible] the FlexDirect card.
[illegible] for an eligible HCSA
[illegible] ically will be used
[illegible] the FlexDirect
[illegible] for any expenses for
[illegible] card.

[illegible]
[illegible] 30 of the calendar
[illegible] incur the eligible
[illegible] ment. If mailing
[illegible] postmarked no later
[illegible].

[illegible] pense during the
[illegible] 1-March 15) and
[illegible] ing prior your
[illegible] 30 of the year in
[illegible] to submit a claim
[illegible].

Checking the status of your claim

You can check the status of your claims at any time by accessing account information at **https://www.flexdirect.adp.com/citigroup**.

Reimbursements

At any time, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred after the date of the qualified change in status.

Using HCSA [illegible] termination of employment

If you terminate employment with Citigroup, you can continue your HCSA coverage under COBRA. If you don't continue coverage under COBRA, you can't use the account for expenses incurred beyond your termination date. However, you will have until the following June 30 to submit your claims.

Effect [illegible]

Even though you reduce your taxable income by using the spending account(s), you aren't reducing your pay for determining any group pay-related benefits, such as disability, life insurance, or pension. Benefits under these Plans are based on your total compensation before your spending account contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your HCSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you can't claim a deduction for an expense on your tax return if you've been reimbursed for the same expense through the HCSA.

Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

DING

Qualifying individuals

According to IRS rules, you may be reimbursed only for expenses incurred in caring for a qualifying individual. Generally, a qualifying individual includes:

- Each of your children under age 13 who must share your residence for more than half the year and must not provide more than half of his or her own support;
- Your spouse who is physically or mentally unable to care for himself or herself and resides with you for more than half the year; and
- Dependents who are mentally or physically unable to care for themselves, reside with you for more than half the year, and who have gross income of less than the dependency exemption threshold ($3,200 in 2005).

How marital status affects your DCSA contribution

If you file a joint tax return: You and your spouse together may contribute up to $5,000 a year before taxes to DCSAs. For example, if your spouse contributes $2,000 to his or her employer's DCSA, you can contribute up to $3,000 to yours. If either you or your spouse earns less than $5,000 annually, the combined amount you and your spouse contribute can't exceed the lower salary.

If you file separate tax returns: You and your spouse each may contribute up to $2,500 a year before taxes to your respective DCSAs.

If your spouse doesn't work: In general, you can't use the DCSA if your spouse doesn't work, unless he or she is a full-time student for at least five months during the calendar year, is looking for work, or is disabled.

To determine the maximum contribution in these cases, your spouse is considered to earn $250 a month if you have one qualified dependent or $500 a month if you have two or more qualified dependents. For Plan purposes, count only the months that your spouse is either a student or disabled.

These limits are subject to change.

[illegible]	ACCOUNT RULES AND FEATURES
[illegible]	Care at a licensed nursery school, day camp (excluding specialty camp), or day care center (the facility must comply with state and local regulations, serve more than six individuals, and receive fees for services); Services from individuals who provide dependent day care in or outside your home, unless the provider is your spouse, your own child under age 19, or any other dependent (these individuals must provide their Social Security numbers to you); After-school care for children under age 13; Household services related to the care of an elderly or disabled adult who lives with you; Your portion of FICA and other taxes that you pay for a care provider; and Any other services that qualify as dependent care under IRS rules.
[illegible]	Expenses for food, clothing, or education; Expenses for transportation between your house and the place that provides day care services or the cost of transportation from a care provider; Expenses for dependent care when either you or your spouse isn't working; Charges for convalescent or nursing home care for a parent or disabled spouse; Overnight camp expenses; Expenses for dependent care that enables you or your spouse to do volunteer work; Payments made to your spouse, your own child under age 19, or any other dependent; and Expenses for which you take the dependent care tax credit.
[illegible]	For more information about eligible people, rules, and expenses, see *IRS Publication 503, Child and Dependent Care Expenses* at http://www.irs.gov or contact your tax adviser. You also can call the IRS at 1-800-[illegible]-1040. Note: The IRS publication is a guide for you when preparing tax returns; it isn't a description of the Citigroup Plan.

[illegible] of the calendar year [illegible] an eligible expense [illegible] example, you'll [illegible] for reimburse- [illegible] (Your envelope must [illegible] 2007.)

[illegible] that exceed the [illegible]

- [illegible] claim exceeds your [illegible] reimbursed up to [illegible] amount of your [illegible] after the next [illegible] are added to your [illegible] paid on the money in [illegible]
- [illegible] attempt to use the [illegible] Direct [illegible] in excess of your [illegible] expense will be [illegible] to be reimbursed [illegible]

[illegible] from your DCSA [illegible] day [illegible] group or [illegible]

[illegible] subsidy of $1,000, [illegible] tax-free from your DCSA [illegible] $4,000, any amount [illegible] included as taxable [illegible] Tax Statement for [illegible]

[illegible] income by using [illegible] your pay [illegible] benefits, such [illegible] benefits under [illegible] before your [illegible]

[illegible] participation on Social Security
Your [illegible] account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

Using DCSA after your termination of employment
You can't use the balance in your account to reimburse yourself for expenses incurred after you terminate employment. However, you'll have until the following June 30 to submit your claims.

[illegible] information
Call the [illegible] Spending Information Line at 1-800-378-[illegible]. Automated information is available 24 hours a day, and you can speak with a representative from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

DCSA subsidy
If you [illegible] and you elect the DCSA subsidy during [illegible] either as a new hire or during annual enrollment, [illegible] Group will pay up to 30% of your DCSA contributions. [illegible] percentage will depend on the amount of your total compensation and whether you work part time [illegible]. *You must enroll for the subsidy during your enrollment period. You can't receive the subsidy through any other process.*

You're eligible for a subsidy if you enroll in the DCSA and on your enrollment date:

- You're [illegible] **financial provider:** Your total compensation [illegible] total annual household income together does [illegible],000, or
- You [illegible] **income household:** Your total compensation doesn't exceed $45,000 *and* your total annual household income doesn't exceed $90,000.

which you make a charge.

Note: Typically, [illegible] announce the annual maximum contribution for the following year after Citigroup's enrollment materials have been printed. Look for maximum contribution amounts at **https://www.flex[illegible].com/citigroup**.

EXAMPLES OF ELIGIBLE EXPENSES

Parking Account

- Parking at or near your work location and
- Parking at or near a location from which you commute to work by mass transportation, car pool, or other means

Transit Account

- Transportation passes;
- Any pass, token, fare card, ticket, or similar item that entitles you to ride public transportation to and from work;
- Transportation between work and your residence in a "commuter highway vehicle" that:
  - Seats six or more adults excluding the driver;
  - Is used 80% or more (based on mileage) for transporting employees between work and home; and
  - Includes at least three commuters, excluding the driver, on each trip.

EXAMPLES OF INELIGIBLE EXPENSES

Parking Account

- Non-work-related parking expenses;
- Parking at or near your residence;
- Parking for which you receive a pretax benefit;
- Parking paid for by your employer;
- Parking expenses incurred by family members; and
- Expenses eligible to be reimbursed from the Transit Account.

Transit Account

- Car pooling and/or van pooling in a vehicle seating fewer than six passengers, excluding the driver;
- Taxi fares;
- Highway, bridge, or tunnel tolls;
- Expenses incurred for business travel (such as traveling from the office to a business or client meeting);
- Gas or mileage expenses;
- Transit expenses incurred by family members; and
- Expenses eligible to be reimbursed from the Parking Account.

Changing your TRIP contribution amount

You can change your monthly contribution amount at any time; the change will be effective the first of the following month and will be shown in that month's pay

If you forget to make a change ahead of time, for example, before you go on vacation or a business trip, you can reduce your future election amount so you can use unclaimed funds. You also can change your monthly contribution to zero and continue to send in receipts for any balance remaining in your account.

To change your election once enrolled:

- *Call ConnectOne at 1-800-881-3938.* From the main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center and then the prompts to change your TRIP election
- Visit Total Comp at Citigroup at **https://www.total-componline.com**, then link to the Citigroup Benefits Web Site.

Reimbursements

You can be reimbursed:

- At the point of purchase by using your Citigroup FlexDirect debit card.
- By completing and returning a TRIP claim form and any required documentation. Reimbursements are processed each business day. Most reimbursements will be made via direct deposit into a bank account.

Filing a claim

See "How to file a claim" on page 19.

Carryovers

Your contributions carry forward from month to month. However, you can make a qualified purchase or be reimbursed only up to the statutory pretax maximum, currently $105 for transit expenses and $200 for parking expenses.

For example, if you enroll to contribute $105 a month to a Transit Account and submit monthly receipts for January 2006 for $120, you'll be reimbursed for $105 only. The remainder of the claim ($15) won't be paid.

Your balance at year-end

Claims must be filed within 12 months of the date of service. Unclaimed 2006 contributions will be rolled over into your 2007 account as of January 1, 2007.

Forfeiting your contributions

If your Transit and/or Parking Account remains inactive for 12 consecutive months (no contributions made or claims filed), you'll forfeit any remaining contributions.

If you terminate employment

If you terminate employment with Citigroup, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You'll have 12 months from the date your expense was incurred to submit claims. You'll forfeit any unclaimed amounts.

For more information

Call the Citigroup Spending Account Information Line at 1-800-378-1823. Automated information is available 24 hours a day, and you can speak with a representative from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.